Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
			-			
		MHL089-003	<u> </u>		12/1	0/2021
	PROVIDER OR SUPPLIER	601 NORT	DRESS, CITY, S T H LIGHT ST	STATE, ZIP CODE 'REET		
TYRREL	L COUNTY GROUP H	OME	A, NC 2792			
(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 000 INITIAL COMMENTS		V 000				
An annual survey was completed on December 10, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised						
Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 currents.						
V 112	V 112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan		V 112			
	PLAN (c) The plan shall the assessment, and in legally responsible of admission for clic receive services beto (d) The plan shall in (1) client outcome (achieved by provisi projected date of action (2) strategies; (3) staff responsible (4) a schedule for annually in consultar responsible person (5) basis for evaluation outcome achievem (6) written consent responsible party, consultar responsible party responsible party responsible party responsible party responsible party responsible party responsible	de developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include: (a) that are anticipated to be on of the service and a chievement; (b) the plan at least attion with the client or legally or both; (a) attion or assessment of				

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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:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL089-003	B. WING		12/1	0/2021
	PROVIDER OR SUPPLIER	OME 601 NORT	DRESS, CITY, S TH LIGHT ST IA, NC 2792			
(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 112	This Rule is not me Based on record re failed to ensure goat to meet client need: #3) audited. The fir Reviews between 1 #3's record reveale-59 year old male a 7/27/94Diagnoses include Disability- Profound Depressive Disorder Incontinence; Cons Microcephaly; Apha Rhinitis; Hypertensi EyeClient #3's treatmer goals or strategies waking in the middle furniture around in Inno goals or strategies waking clothing a bedroomRisk support/need: documented client; due to the inability thome"	et as evidenced by: view and interview, the facility als/strategies were developed a affecting 1 of 3 clients (client addings are: 2/9/21 and 12/10/21 of client d: dmitted to the facility on d Intellectual Developmental ; Anxiety Disorder by History; er by History; Epilepsy; tipation; Cerebral Palsy; asia; Drooling Saliva; Allergic on; High Cholesterol and Dry ent plan dated 2/1/21 had no to address safety issues of e of the night to move his bedroom. gies to address Client #3 and shoes around in hs assessment dated 12/1/20 #3's requirement of "support o make safe choices when at	V 112			
	unsuccessful due to	with client #3 on 12/9/21 was his communication deficits. 21 with Client #3's Guardian lue to no return call to the				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL089-003	B. WING		12/1	0/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S FH LIGHT ST	STATE, ZIP CODE		
TYRREL	L COUNTY GROUP H	OME	IA, NC 2792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y 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)	LD BE	(X5) COMPLETE DATE
V 112	Continued From pa	ige 2	V 112			
	surveyor.					
	Professional stated -She had worked a -She supervised the client's treatment te -She visited the factor more as needed -She had not conta Coordinator regard address Client #4's	t the facility since 1986. e facility and participated in the eam meetings. ility at least two times monthly				
V 119	27G .0209 (D) Med	lication Requirements	V 119			
	V 119 27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL089-003	B. WING		12/	10/2021
	PROVIDER OR SUPPLIER	OMF 601 NOR	DDRESS, CITY, S TH LIGHT ST BIA, NC 2792			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 119	disposed of prompt expected that the p to the facility and in drug supply shall no calendar days after	ly unless it is reasonably atient or resident shall return such case, the remaining of be held for more than 30 the date of discharge.	V 119			
	failed to dispose of manner that guards accidental ingestion. The findings are: Review on 12/9/21 record revealed: -72 year old male a -Diagnoses include Developmental Distance Mellitus; Hypertens -Client #2's physicial discontinue Toujeo.	d Severe Intellectual abilities; Type II Diabetes ion and Hyperlipidemia. ans order dated 4/6/20 to				
	at approximately 4: -Basaglar (Toujeo) injector pen inside (box, with label instr	(treats diabetes) 100 units Client #2's refrigerated lock uctions of 22 units at bedtime, ull and with a dispense date of 1 Client #2 stated: ation daily. his medication.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL089-003	B. WING		12/1	0/2021
	PROVIDER OR SUPPLIER L COUNTY GROUP H	OMF 601 NORT	DRESS, CITY, S TH LIGHT ST A, NC 2792			
(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)	LD BE	(X5) COMPLETE DATE
V 119	-She had worked at -She had trained in administered medic -Client #2 had not resince it had been di Interview on 12/10/2 stated: -The Basaglar (Toubeen discontinued -Medications that wheen taken to the discontinued the pharmacyClient #2 had not be Basaglar (Toujeo) in discontinued.	the facility for almost 9 years. medication administration and ration. ecceived the Basaglar injection scontinued. 21 the Qualified Professional jeo) 100 units injector pen had	V 119			
V 364	§ 122C-62. Addition Facilities. (a) In addition to the 122C-51 through Gowho is receiving tree 24-hour facility keeped (1) Send and receivances to writing meassistance when noted (2) Contact and cound at no cost to the physicians, and privide velopmental disapprofessionals of his (3) Contact and countere is a client advother in the rights specified the second transfer of the second tran	ve sealed mail and have aterial, postage, and staff ecessary; nsult with, at his own expense e facility, legal counsel, private rate mental health, bilities, or substance abuse choice; and nsult with a client advocate if	V 364			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B 14/11/0			
		MHL089-003	B. WING		12/1	0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TYRREL	L COUNTY GROUP H	OME	H LIGHT ST A, NC 2792			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 364	exercise these right (b) Except as prov of this section, each treatment or habilitatimes keeps the rig (1) Make and rece calls. All long distar the client at the time collect to the receiv (2) Receive visitors a.m. and 9:00 p.m. hours daily, two hou p.m.; however visition over therapies; (3) Communicate as supervision with incurrent upon the consent o (4) Make visits out unless: a. Commitment pour the result of the clie violent crime, include assault with a dead respondent was for insanity or incapable b. The client was committed to the factor commitment to a commitme	its at all reasonable times. ided in subsections (e) and (h) in adult client who is receiving ation in a 24-hour facility at all int to: ive confidential telephone ince calls shall be paid for by ite of making the call or made ing party; is between the hours of 8:00 for a period of at least six iurs of which shall be after 6:00 ing shall not take precedence and meet under appropriate lividuals of his own choice if the individuals; iside the custody of the facility incoceedings were initiated as ant's being charged with a ding a crime involving an ily weapon, and the ind not guilty by reason of ie of proceeding; voluntarily admitted or cility while under order of increctional facility of the increction of the Department of ing held to determine capacity it to G.S. 15A-1002; expressly authorize visits d by the existence of the ied by this subdivision; it daily and have access to ment for physical exercise	V 364	DELIGITACITY		

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CR6811 If continuation sheet 6 of 12

ווטופוזיום	Of Fleatill Service IN	guiation	ī		ı	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LΕTED
		MHL089-003	B. WING	B. WING		0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	-	
747 HVIL OI I	VIDER OR OUT FEILIN		TH LIGHT ST			
TYRRELL COUNTY GROUP HOME		A, NC 2792				
			A, NC 2/92			
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
1710		,	1710	DEFICIENCY)		
V 364	Continued From no	go 6	V 364			
V 304	Continued From pa		V 304			
		nd possessions, unless the				
		to determine capacity to				
	proceed pursuant to	o G.S. 15A-1002;				
	(7) Participate in re					
	(8) Keep and spen	d a reasonable sum of his				
	own money;					<u> </u>
		s license, unless otherwise				<u> </u>
		er 20 of the General Statutes;				
	and					
	(10)Have access to individual storage space for					
	his private use.					
		e rights enumerated in G.S.				
		.S. 122C-57 and G.S.				
		.S. 122C-61, each minor client				
		atment or habilitation in a				
		the right to have access to				
		ision and guidance. In				
		ninor's status as a developing				
	individual, the mino					
		able him to mature physically,				
	emotionally, intelled	of the physical, emotional,				
		naturity of the minor, the				
		I provide appropriate				<u> </u>
		on and control consistent with				<u> </u>
	, ,	he minor pursuant to this Part.				<u> </u>
		o, where practical, make				<u> </u>
		o ensure that each minor				<u> </u>
		ment apart and separate from				<u> </u>
		the treatment needs of the				
	minor client dictate					<u> </u>
	Each minor client w	ho is receiving treatment or				<u> </u>
		24-hour facility has the right to:				<u> </u>
		and consult with his parents or				<u> </u>
		ncy or individual having legal				<u> </u>
	custody of him;					<u> </u>
		nsult with, at his own expense				<u> </u>
		responsible person and at no				<u> </u>
		egal counsel, private				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. BOILDING.			
	MHL089-003	B. WING		12/10/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TYRRELL COUNTY GROUP HO	MI-	H LIGHT ST A, NC 2792			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
disabilities, or substate his or his legally respectation (3). Contact and constitute is a client advocation there is a client advocation there is a client advocation the rights specified in restricted by the facility may exercise these restricted by the facility may exercise these restricted for the facility of this section, each attreatment or habilitation the right to: (1) Make and received distance calls shall be time of making the careceiving party; (2) Send and received writing materials, possive writing materials, possive writing materials, possive writing materials, possible to see the p.m. for a period of a hours of which shall be visiting shall not take therapies; (4) Receive special extraining in accordance (5) Be out of doors determining in accordance (6) Except as prohib personal clothing and appropriate supervising held to determine capes (3). 15A-1002; (7) Participate in religion (8) Have access to in the safekeeping of personal clothing and the s	nental health, developmental ince abuse professionals, of consible person's choice; and sult with a client advocate, if cate. In this subsection may not be ity and each minor client rights at all reasonable times, ed in subsections (e) and (h) minor client who is receiving ion in a 24-hour facility has be telephone calls. All long e paid for by the client at the fall or made collect to the end and staff assistance the supervision, receive thours of 8:00 a.m. and 9:00 at least six hours daily, two be after 6:00 p.m.; however precedence over school or education and vocational the with federal and State law; daily and participate in play, ical exercise on a regular with his needs; with his needs; with his needs; with this needs;	V 364			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL089-003	B. WING		12/10/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
		601 NORT	H LIGHT ST			
TYRRELL COUNTY GROUP HOME COLUME			A, NC 2792	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 364	Continued From page 8		V 364			
	prohibited by Chapt (e) No right enume of this section may by the qualified prof formulation of the c plan. A written state client's record that i for the restriction. T reasonable and rela habilitation needs. A period not to excee each restriction sha qualified profession at which time the re Each evaluation of documented in the rights may be renev statement entered be the client's record the renewal of the restriction of rights who has not be in each instance of of a restriction of rights be notified of the re it. In the case of a re adult client, the legal be notified of each or renewal of a rest reason for it. Notifice individual or legally	and solicense, unless otherwise ser 20 of the General Statutes. For atted in subsections (b) or (d) be limited or restricted except fessional responsible for the lient's treatment or habilitation ement shall be placed in the indicates the detailed reason the restriction shall be atted to the client's treatment or a restriction is effective for a did 30 days. An evaluation of all be conducted by the all at least every seven days, estriction may be removed. The arestriction shall be client's record. Restrictions on wed only by a written by the qualified professional in the tates the reason for the iction. In the case of an adult been adjudicated incompetent, an initial restriction or renewal ghts, an individual designated upon the consent of the client, striction and of the reason for minor client or an incompetent ally responsible person shall instance of an initial restriction riction of rights and of the responsible person shall be and in the client's record.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL089-003	B. WING		12/1	0/2021
	PROVIDER OR SUPPLIER L COUNTY GROUP H	OMF 601 NORT	DRESS, CITY, S TH LIGHT ST IA, NC 2792			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	JLD BE	(X5) COMPLETE DATE
V 364	This Rule is not me Based on observati interviews, the facili of clients access to reasonable and relahabilitation needs a required for 1 of 3 a findings are: Review on 12/9/21 -59 year old male a 7/27/94Diagnoses include Disability- Profound Depressive Disorde Incontinence; Cons Microcephaly; Apha Rhinitis; Hypertensi EyeNo documentation some of Client #3's bedroom and place beside Client #3's betroom and place beside Client #3's clothing Client #3's clothing documented evaluation the Qualified Profeston on 12/10 of Client #3's bedroom of the reston his clothing or performance of the Poservation on 12/10 of Client #3's bedroom and place to his clothing or performance of the reston his closet.	et as evidenced by: on, record reviews and ity failed to ensure restriction personal property was ated to clients' treatment or nd was documented as audited clients (#3). The of Client #3's record revealed: dmitted to the facility on d Intellectual Developmental t; Anxiety Disorder by History; er by History; Epilepsy; tipation; Cerebral Palsy; asia; Drooling Saliva; Allergic on; High Cholesterol and Dry regarding the removal of clothing and shoes from his d into a vacant bedroom bedroom. No written the reason for the removal of and shoes and no ation every 7 days of the the restriction conducted by asional (QP). of notification of Client #1's triction of the client's access ersonal belongings.	V 364			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL089-003	B. WING		12/	10/2021
	PROVIDER OR SUPPLIER L COUNTY GROUP H	OMF 601 NOR	DRESS, CITY, S TH LIGHT STI IA, NC 27925			
(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 364	Observation 12/9/2 a vacant bedroom In The vacant Bedroom In	1 at approximately 3:35 pm of revealed: om was beside Client #3's e kit with toothbrush, soap and othes hamper with clothing sided dresser with mirror with onging to Client #3 in the with Client #3's underwear in rts in the second drawer and drawer. client #3 on 12/9/21 and mmunication deficits. 21 with Client #3's Guardian due to no return call to the n 12/9/21 and 12/10/21 the nal stated: s clothing and shoes had been at bedroom as safety measure. In moving furniture and taking from the closet and dresser ep hours. In g to prevent Client #3 from or clothes on the floor or the nim. ed his dresser with mirror had thrown shoes can clothes	V 364			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL089-003	B. WING		12/10/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TYRREL	L COUNTY GROUP H	CIME	TH LIGHT ST IA, NC 2792			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y 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 364	was in agreementThere was no doct days of the continu- Client #3's belongir -Client #3's care co	umented evaluation every 7 ed need for the restriction of	V 364			

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