Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	′
			A. BUILDING: _	A. BUILDING:		
		MHL049-116	B. WING		12/17/202	21
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHESTNU	T GROVE		ANDREWS RO LE, NC 28625			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		MPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was Deficiencies were cite	s completed on 12/17/2021 ed.				
	category: 10A NCAC	d for the following service 27G .5100 Community ndividuals of All Disability				
	The survey sample co	onsisted of audits of 2				
V 536	27E .0107 Client Right Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person v property damage is p (c) Provider agencies based on state compe compliance and demo gathered. (d) The training shall include measurable le measurable testing (v behavior) on those of	plement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and eating an environment in fimminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal constrate they acted on data				

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

(X6) DATE TITLE

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

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Division of Health Service Regulation

DIVISION	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
			-		
		MHL049-116	B. WING		12/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	II E, ZIP CODE	
CHESTNU	T CDOVE	303 SAIN	T ANDREWS R	DAD	
CHESTNO	I GROVE	STATES	/ILLE, NC 2862	5	
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	<u> </u>
				DEFICIENCY)	
V 536	Continued From page	e 2	V 536		
	(D)l				
		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) Instructor Qualifica				
	Requirements:	9			
	•	all demonstrate competence			
		•			
		esting in a training program			
		reducing and eliminating the			
	need for restrictive int	terventions.			
	(2) Trainers sha	all demonstrate competence			
	by scoring a passing	grade on testing in an			
	instructor training pro				
	(3) The training				
		nclude measurable learning			
	•	le testing (written and by			
		ior) on those objectives and			
	measurable methods	to determine passing or			
	failing the course.				
	(4) The content	t of the instructor training the			
	service provider plans	S S			
		sion of MH/DD/SAS pursuant			
	• • •	•			
	to Subparagraph (i)(5				
	` '	instructor training programs			
		not limited to presentation of:			
		ng the adult learner;			
	(B) methods for	r teaching content of the			
	course;				
	•	r evaluating trainee			
	performance; and	<b>5</b>			
	•	ion procedures.			
	` '	all have coached experience			
		ogram aimed at preventing,			
	•	ting the need for restrictive			
	interventions at least	one time, with positive			
	review by the coach.	·			
		all teach a training program			
		reducing and eliminating the			
	need for restrictive inf	terventions at least once	1		

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 3 of 11

Division of	<u>of Health Service Regu</u>	lation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			· ·				
		MUU 040 446	B. WING		40/47/00	104	
		MHL049-116			12/17/20	)21	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
		303 SAIN	IT ANDREWS RO	OAD			
CHESTNU	T GROVE		VILLE, NC 2862				
	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0.45	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) OMPLETE	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
				DEFICIENCY)			
V 536	Continued From page	. 2	V 536				
V 330	Continued From page	<del>-</del> 3	V 330				
	annually.						
	(8) Trainers sha	all complete a refresher					
	instructor training at le	east every two years.					
	(j) Service providers						
	documentation of initi	al and refresher instructor					
	training for at least th						
	· /	entation shall include:					
		ated in the training and the					
	outcomes (pass/fail);						
	` '	vhere attended; and					
	(C) instructor's						
		n of MH/DD/SAS may					
		nis documentation any time.					
	(k) Qualifications of (						
	• •	nall meet all preparation					
	requirements as a tra						
	` '	nall teach at least three times					
	the course which is b	-					
	(-)	nall demonstrate					
	competence by comp	_					
		nall be the same preparation					
	as for trainers.	iali be the same preparation					
	as ioi trainers.						
	This Rule is not met	as evidenced by:					
		ew and interviews, the					
		e staff completed training on					
	•	tive interventions prior to					
		ecting 1 of 3 audited staff					
		Director (RCD)); and failed					
	•	esher training was completed					
		cting 1 of 3 audited staff					
	(#1). The findings are	~					
	. ,		1	l .			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	D. WING				
		MHL049-116	B. WING		12/17/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 536	Continued From page	· 4	V 536		
	record revealed: - Hire date: 2/24/2020 - Documentation that restrictive intervention - Refresher training w 7/13/2021.  Reviews on 12/16/2021 Reviews on 12/16/2021 - Reviews on 12/16/2021 - Documentation that restrictive intervention 6/9/2021 - No documentation that restrictive intervention that restrictive intervention 6/9/2021 - No documentation that restrictive intervention that restrictive intervention 6/9/2021 - No documentation that restrictive intervention that restrictive intervention 12/16/20 - She remembered has alternatives to restrict know why it had taken refresher training.  Interview on 12/16/20 - She had attended the training on alternative curriculum but had noted that the person respectation of	training on alternatives to as had expired on 3/3/2021. Fas not completed until 21 & 12/17/2021 of the ord revealed:  training on alternatives to as was not begun until anat training on alternatives ions was fully completed.  21 with Staff #1 revealed: ave attended the training on ive interventions, but did not a so long for her to get the 21 with the RCD revealed: are first part of the facility's as to restrictive interventions but yet attended the final part. Sees Manager (HRM) had onsible for scheduling her is hired.			

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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:		(X3) DATE SURVEY COMPLETED		
			P WING			
		MHL049-116	B. WING		12/17	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHESTNU	T GROVE		ANDREWS RO			
			LE, NC 28625	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 536	Continued From page	÷ 5	V 536			
	training on alternative	d taking the first part of the sto restrictive interventions ampleted the final part.				
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OL  (a) Seclusion, physic time-out may be employed the entrained and have competence in the proto these procedures. staff authorized to emprocedures are retrain competence at least a (b) Prior to providing of disabilities whose treat includes restrictive into service providers, emvolunteers shall composeclusion, physical reand shall not use these training is completed demonstrated.	CAL RESTRAINT AND JT al restraint and isolation loyed only by staff who have e demonstrated oper use of and alternatives Facilities shall ensure that uploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including ployees, students or olete training in the use of straint and isolation time-out se interventions until the and competence is				
	(c) A pre-requisite for demonstrating competraining in preventing, the need for restrictive (d) The training shall include measurable testing (vibehavior) on those obmethods to determine course.  (e) Formal refresher	etence by completion of reducing and eliminating e interventions. be competency-based,				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 6 of 11

Division c	<u>of Health Service Regu</u>	ılation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
		MHL049-116	B. WING		12/1	7/2021
		WITE043-110			1 12/1	112021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CHESTNU	IT CDOVE	303 SAIN	T ANDREWS RO	DAD		
CHESTNO	I GROVE	STATES	/ILLE, NC 28625	;		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
V 537	Continued From page	e 6	V 537			
	annually)					
	annually).	ining that the consider				
	(f) Content of the trai	<del>-</del>				
		oloy must be approved by				
	the Division of MH/DI					
	Paragraph (g) of this					
		ng programs shall include,				
	but are not limited to,	•				
	( )	formation on alternatives to				
	the use of restrictive i					
		on when to intervene				
	, -	nent danger to self and				
	others);					
		on safety and respect for the				
		all persons involved (using				
		trictive interventions and				
	incremental steps in a					
		or the safe implementation				
	of restrictive intervent					
		emergency safety				
	interventions which in					
		nitoring of the physical and				
		eing of the client and the safe				
	-	ghout the duration of the				
	restrictive intervention	,				
	(6) prohibited p					
	, , ,	strategies, including their				
	importance and purpo					
	(8) documentat (h) Service providers	tion methods/procedures.				
		ial and refresher training for				
	at least three years.	al and reflesher training for				
	,	tion shall include:				
	` '	pated in the training and the				
	<ul><li>(A) who particip outcomes (pass/fail);</li></ul>					
		where they attended; and				ı
	· ,					
	\ - <i>/</i>					ı
		n of MH/DD/SAS may				
		ocumentation at any time.				ı
ļ	(i) Instructor Qualification	ation and Training				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 7 of 11

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MHL049-116	B. WING		40/47/2024
		MITEU49-116			12/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		303 SAIN	ANDREWS RO	DAD	
CHESTNU	T GROVE	STATESV	LLE, NC 2862	5	
0(1) 15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d over
(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 APPROPE	RIATE DATE
				DEFICIENCY)	
V 537	Continued From page	2.7	V 537		
	. •	•			
	Requirements:				
	` ,	all demonstrate competence			
		esting in a training program			
		reducing and eliminating the			
	need for restrictive int				
		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.	to determine passing or			
	-	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:	71			
	(A) understandi	ng the adult learner;			
		r teaching content of the			
	course;				
	(C) evaluation of	of trainee performance; and			
	(D) documentat	ion procedures.			
	(7) Trainers sha	all be retrained at least			
		trate competence in the use			
		restraint and isolation			
	time-out, as specified	in Paragraph (a) of this			
	Rule.				
	` ,	all be currently trained in			
	CPR.				
		all have coached experience			
	in teaching the use of	restrictive interventions at			

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ED
		MUI 040 446	B. WING		40/47/	10004
		MHL049-116			12/17/	2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		303 SAIN	NT ANDREWS RO	DAD		
CHESTNU	T GROVE	STATES	VILLE, NC 28625	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
V 537	Continued From page	8	V 537			
	least two times with a	positive review by the				
	coach.	•				
	(10) Trainers sha	all teach a program on the				
	` ,	ventions at least once				
	annually.					
	(11) Trainers sha	all complete a refresher				
	instructor training at le					
	(k) Service providers					
	documentation of initi	al and refresher instructor				
	training for at least the	ree years.				
	(1) Documenta	tion shall include:				
		ated in the training and the				
	outcome (pass/fail);					
		where they attended; and				
	(C) instructor's	name.				
	(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	all meet all preparation				
	requirements as a tra	iner.				
	(2) Coaches sh	all teach at least three				
	times, the course whi	ch is being coached.				
	(3) Coaches sh	all demonstrate				
	competence by comp	letion of coaching or				
	train-the-trainer instru	ction.				
	(m) Documentation s					
	preparation as for trai	ners.				
	This Rule is not met					
		ew and interviews, the				
	-	e staff completed training in				
		straint and isolation time out				
		vices affecting 1 of 3 audited				
		enter Director (RCD)); and				
		al refresher training was				
	completed at least an	nually affecting 1 of 3				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 9 of 11

Division of Health Service Regulation

AND DI AN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			_			
		MHL049-116	B. WING		12/17/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHESTNU	T GROVE		ANDREWS RO			
			LE, 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 APPROPF DEFICIENCY)	BE COMPL	LETE
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.  Reviews on 12/16/2021 Documentation that physical restraint and begun until 6/9/2021 No documentation the physical restraint and completed.  Interview on 12/16/2021 She remembered has seclusion, physical restraint and seclusion.	training in seclusion, isolation time out had as not completed until 21 & 12/17/2021 of the ord revealed: Itraining in seclusion, isolation time out was not mat training in seclusion, isolation time out was fully 21 with Staff #1 revealed: ave attended the training in straint and isolation time why it had taken so long for				
	- She had attended the training in seclusion, properties is solution time out currulattended the final particular. The Human Resource	iculum but had not yet t. ces Manager (HRM) had onsible for scheduling her				
	Interview on 12/17/20 Resources Manager r - Training in seclusion	21 with the Human				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL049-116	B. WING		12	/17/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
CHESTNU	JT GROVE		NT ANDREWS ROA VILLE, NC 28625	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 537	the RCD due to COV to class size and the - 4 of the 5 trainers ir had left, leaving the f one person The RCD had started training in seclusion,	e 10  ID-19 pandemic restrictions lack of available trainers.  In the local Licensee office full load of training all staff on ed taking the first part of the physical restraint and larse but had not completed	V 537			

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