Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		MHL049-116	B. WING		12/17/2021	
NAME OF PE	ROVIDER OR SUPPLIER	303 SAIN	DDRESS, CITY, STANDREWS R	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE	E
V 000	An annual survey was Deficiencies were cited. This facility is licensed category: 10A NCAC	d for the following service 27G .5100 Community ndividuals of All Disability	V 000			
V 536	Int. 10A NCAC 27E .0107 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall impractices that emphasto restrictive intervent (b) Prior to providing disabilities, staff incluemployees, students demonstrate compete completing training in other strategies for crwhich the likelihood or injury to a person verification property damage is property damage is property damage is property damage in pro	competency-based,	V 536	V 536 / V 537 RCD completed Alternatives to Restrictive Intervention training on 12/28/21 and 12/2 Meaures put in place: -Future employees will not be permitted to Resource Center until Alternative to Rest Intervention training is completed. Who will monitor: -Lead Counselor, RCD, Assistant Director will montior monthly to ensure compliance V 536 / V 537 Staff #1 completed their annual recertifica Training in physical restraint on Tuesday, July 13, 2021. Measures put in place: -Future employees will not be permitted to Resource Center until annual recertification is completed. Who will monitor: -Lead Counselor, RCD, Assistant Director will monitor monthly to ensure compliance	work at the cictive and HRM exition work at the con Training and HRM	

Division of Health Service Regulation

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

TITLE (X6) DATE

Michelle Kluttz, RHA State START Director

12/20/21

STATE FORM 6899 If continuation sheet 1 of 11 Z94T11

Division of Health Service Regulation

DIVISION	n Health Service Negu	lation			
			(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
		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			(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	ORESS, 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 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	IAIE DATE
			+	,	
V 536	Continued From page	2	V 536		
	(D) when and w	where they ettended, 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:				
		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	gram.			
	(3) The training	ı shall be			
	competency-based, ir	nclude measurable learning			
	objectives, measurab	le testing (written and by			
	observation of behavi	or) on those objectives and			
	measurable methods	to determine passing or			
	failing the course.				
	_	t of the instructor training the			
	service provider plans	s to employ shall be			
		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			
	course;	r todorning deriterit or the			
	•	r evaluating trainee			
	performance; and				
	•	ion procedures.			
		all have coached experience			
		ogram aimed at preventing,			
		ing the need for restrictive			
		one time, with positive			
		one une, with positive			
	review by the coach.	all tagab a training your servers			
		all teach a training program			
		reducing and eliminating the			
	need for restrictive inf	terventions at least once			

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 (PLAN OF CORRECTION IDENTIFICATION NUMBER: 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			
240.15	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			TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 536	Continued From page	. 2	V 536			
V 330	Continued From page	- 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 tile 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

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:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING	A. BOILDING.		
		MHL049-116	B. WING		12/1	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHESTNU	IT GROVE		ANDREWS ROLLE, NC 28625			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETE DATE
V 536	Continued From page	e 4	V 536			
	record revealed: - Hire date: 2/24/2020 - Documentation that restrictive interventior - Refresher training w 7/13/2021. Reviews on 12/16/202 RCD's employee recordant desired that restrictive intervention 6/9/2021 No documentation that restrictive intervention to restrictive intervention that restricti	training on alternatives to his had expired on 3/3/2021. was not completed until 21 & 12/17/2021 of the ord revealed:				
	- She had attended the training on alternative curriculum but had no - The Human Resource	note that the RCD revealed: the first part of the facility's test to restrictive interventions to yet attended the final part. the ses Manager (HRM) had the onsible for scheduling her to hired.				
	- Training on alternati interventions was late RCD due to COVID-1 class size and the lac - 4 of the 5 trainers in	221 with the HRM revealed: ves to restrictive for both Staff #1 and the 9 pandemic restrictions to k of available trainers. the local Licensee office ull load of training all staff on				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11 .		.5	A. BUILDING: _	G:		
		MHL049-116	B. WING		12/1	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
CUECTAIL	IT ODOVE	303 SAINT	ANDREWS RO	DAD		
CHESTNU	II GROVE	STATESVI	LLE, 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 APPROPR 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 impleted the final part.				
V 537	27E .0108 Client Righ	nts - Training in Sec Rest &	V 537			
	ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the proto these procedures. staff authorized to emprocedures are retrain competence at least a (b) Prior to providing disabilities whose traincludes restrictive into service providers, emvolunteers shall compseclusion, physical reand shall not use these training is completed demonstrated. (c) A pre-requisite for demonstrating competraining in preventing, the need for restrictive.	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 aploy and terminate these med 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 as interventions until the and competence is taking this training is etence by completion of reducing and eliminating e interventions.				
	include measurable le measurable testing (v behavior) on those of methods to determine course. (e) Formal refresher	be competency-based, earning objectives, vritten and by observation of ojectives and measurable e passing or failing the training must be completed der periodically (minimum				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		MIII 040 440	B WING		40/47/0004
		MHL049-116	D. WING		12/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		303 SAII	IT ANDREWS RO	DAD	
CHESTNU	T GROVE		VILLE, NC 2862		
			VILLE, NC 2002.		
(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	
IAO		,	IAG	DEFICIENCY)	
			+		
V 537	Continued From page	e 6	V 537		
	annually).				
	(f) Content of the trai	ning that the convice			
	. ,	•			
		ploy 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			
	(understanding immir	nent danger to self and			
	others);				
	(3) emphasis o	n safety and respect for the			
	rights and dignity of a	II persons involved (using			
	concepts of least rest	rictive interventions and			
	incremental steps in a	an intervention);			
	(4) strategies for	or the safe implementation			
	of restrictive intervent	tions;			
	(5) the use of e	mergency safety			
	interventions which in				
	assessment and mon	itoring of the physical and			
		ing of the client and the safe			
		ghout the duration of the			
	restrictive intervention	•			
	(6) prohibited p				
	\	trategies, including their			
	importance and purpo				
		tion methods/procedures.			
	(h) Service providers	•			
		al and refresher training for			
	at least three years.	a. aa ronoonor training for			
	_	tion shall include:			
	` '	ated in the training and the			
	outcomes (pass/fail);	accum me naming and me			
	**	where they attended; and			
	• •	where they attended; and			
	(C) instructor's				
		n of MH/DD/SAS may			
		ocumentation at any time.			
	(i) Instructor Qualification	ation and Training			

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Division of Health Service Regulation

DIVISION	n Health Service Negu	ialion			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		MUI 040 446	B. WING		42/47/2024	
		MHL049-116			12/17/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	- 000V-	303 SAIN	T ANDREWS RO	DAD		
CHESTNU	I GROVE	STATESV	ILLE, NC 28625	5		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5	,
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	(*	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE DAT	E
				DEFICIENCY)		
V 537	Continued From page	e 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	i.				
	(3) Trainers sha	all demonstrate competence				
	by scoring a passing	grade on testing in an				
	instructor training pro-	gram.				
	(4) The training	ı shall be				
	competency-based, ir	nclude measurable learning				
	objectives, measurab	le testing (written and by				
	observation of behavi	or) 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:	,,				
	(A) understandi	ng the adult learner;				
		r teaching content of the				l
	course;	3				
	•	of trainee performance; and				
		ion procedures.				
	• •	all be retrained at least				l
	\ <i>\</i>	trate competence in the use				
		restraint and isolation				
		in Paragraph (a) of this				
	Rule.	aragraph (a) or uno				
		all be currently trained in				
	CPR.	an so darrottay trained in				
		all have coached experience				
		restrictive interventions at				

Division of Health Service Regulation

STATE FORM 6899 Z94T11 If continuation sheet 8 of 11

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL049-116	B. WING		12/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CHESTNU	T GROVE		T ANDREWS RO (ILLE, NC 28625		
(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 537	Continued From page	e 8	V 537		
	least two times with a coach. (10) Trainers sha use of restrictive inter annually. (11) Trainers sha instructor training at le (k) Service providers documentation of initi training for at least the (1) Documenta (A) who particip outcome (pass/fail); (B) when and w (C) instructor's (2) The Division review/request this do (I) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches whitmes, the course whi	all teach a program on the rventions at least once all complete a refresher east every two years. Is shall maintain ial and refresher instructor ree years. Ition shall include: Inated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time. Coaches: Inall meet all preparation inner. Inall teach at least three ich is being coached. Inall demonstrate oletion of coaching or uction. Ishall be the same			
	facility failed to ensure seclusion, physical re prior to providing serve staff (the Resource C failed to ensure formation	as evidenced by: ew and interviews, the e staff completed training in estraint and isolation time out vices affecting 1 of 3 audited tenter Director (RCD)); and al refresher training was anually affecting 1 of 3			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1			SURVEY LETED	
			A. BOILDING	Marko		
		MHL049-116	B. WING		12/	17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CHESTNU	T GROVE	303 SAIN	T ANDREWS RO	DAD		
	- OKOVE	STATESV	ILLE, NC 28625	i		
(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 DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO TO THE PROVIDER OF T	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
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:				
	Interview on 12/16/2021 with Staff #1 revealed: - She remembered have attended the training in seclusion, physical restraint and isolation time out, but did not know why it had taken so long for her to get the refresher 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.				
		revealed: n, physical restraint and a late for both Staff #1 and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	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 functione 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