Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|---|------------|--------------------------|
| ANDILAN | or dorace more | IDENTIFICATION NOMBER. | A. BUILDING: | | J GOWN EE | |
| | | MHL096-277 | B. WING | | 12/04/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| RENU LIF | E EXTENDED INC | | SOR CREEK PA | | | |
| | | | RO, NC 27530 | | 1 | |
| (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 APPROPI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 000 | INITIAL COMMENTS | 3 | V 000 | | | |
| | An annual survey wa 04, 2024. Deficiencie | s completed on December s were cited. | | | | |
| | category: 10A NCAC | d for the following service 27G .5600C Supervised Developmental Disabilities. | | | | |
| | This facility is licensed for 24 and currently has a census of 21. The survey sample consisted of audits of 3 current client. | | | | | |
| V 123 | 27G .0209 (H) Medic | ation Requirements | V 123 | | | |
| | 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. | | | | | |
| | facility failed to ensur reported immediately | as evidenced by: ew and interviews, the e medication refusals were to a physician or pharmacist ed clients (#6 and #7). The | | | | |
| | Finding #1 Review on 12/03/24 or revealed: | of client #6's record | | | | |

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

(X6) DATE TITLE

Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | SURVEY ETED |
|--------------------------|---|--|---------------------|--|-------|--------------------------|
| MIII 000 077 | | B. WING | B WING | | | |
| | | MHL096-277 | B. WIIVO | | 12/0 | 4/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | DDRESS, CITY, STA | | | |
| RENU LIF | E EXTENDED INC | | OSOR CREEK PA | | | |
| | | | ORO, NC 27530 | | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| V 123 | Continued From page | e 1 | V 123 | | | |
| V 123 | - Date of admission: - Diagnoses of Bilater and partial lobe lobot - No documentation a had been notified of rof 2024 to December Review on 12/03/24 order dated 09/25/24 - Ted hose compressis morning and removed (prevent blood clots/of thru December 2024 Records (MAR) reveal-September 20024-Ted | nal subdural hematoma's comy. a physician or pharmacist efusals/errors from October of 2024. of client #6's medication revealed: on stockings applied every d at night daily at 8:00 circulation). of client #6's October 2024 Medication Administration aled: ed Hose refused //12/24,09/13/24,09/15/24,09 | V 123 | | | |
| | /15/24, 10/16/24,10/17/24,10/3/ /21/24,10/27/24,10/3/ -November 2024-Ted 11/01/24,11/02/24,11, 06/24,11/11/24,11/17, 11/23/24 and 11/25/2 -December-Ted Hose Finding #2 Review on 12/03/24 or revealed: - Date of admission: - Diagnoses of Deme trauma. - No documentation a | /12/24,10/13/24,10/14/24,10 //18/24,10/19/24,10/20/24,10 //18/24 and 10/31/24. Hose refused //03/24,11/04/24,11/05/24,11/ //24,11/19/24,11/22/24, 4. e refused 12/01/24. of client #7's record //11/16/05. | | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 2 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|----------------------------|--|-------------------------------|--|
| AND I EAN OF CONNECTION IDENTIFICATION NOWIDEN. | | A. BUILDING: | | COMPLETED | | |
| | | MHL096-277 | B. WING | | 12/04/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| | | 201 WINDS | OR CREEK PA | ARKWAY | | |
| RENU LIF | E EXTENDED INC | GOLDSBO | RO, NC 27530 | 1 | | |
| (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 123 | Continued From page | 2 | V 123 | | | |
| | orders dated 11/25/24 -Amlodipine Besylate daily (angina), Atorva at bedtime (cholester mg three times daily (capsule twice daily (hablet every morning Hydrochlorothiazide 2 pressure), Lisinopril 2 (hypertension/heart fa 25 mg every evening Oxcarbazepine 300 m (seizures), Quetiapine (mood), Thiamine 100 (nervous system), Vit (microgram) tablet ev | 10 mg (milligrams) tablet statin Calcium 20mg tablets ol), Divalproex Sodium 500 (seizures), Fish Oil 1000 mg eart health), Folic Acid 1 mg (cell development), 25 mg tablet daily (high blood 20 mg tablet every morning ailure), Metoprolol Succinate (blood pressure), | | | | |
| | thru December 2024 -October 2024-Divalp 10/22/24, Metoprolol 10/22/24, Quetiapine Fish Oil 1000 mg 10/2 Oxcarbazepine 300 m Atorvastatin 20 mg re-November 2024- Div 11/03/24, 11/12/24/11 Metoprolol Succinate 11/12/24/11/16/24 and 11/19/24, Fish Oil 11/09/24, 11/15/24, 11/2 refused, Oxcarbazepi 11/09/24, 11/15/24, 11/2 oxcarbazepi 11/209/24, 11/25/24, 11/2 oxcarbazepi 11/209/24, 11/25/24, 11/2 oxcarbazepi 11/209/24, 11/25/24, 11/2 oxcarbazepi 11/209/24, 11/25/24, 1 | roex Sodium refused Succinate 25mg refused 300mg refused 10/22/24, 22/24 refused, ng tab 10/22/24 refused, fused 10/22/24. alproex Sodium refused /16/24 and 11/20/24, 25 mg refused 11/03/24, d 11/20/24, Quetiapine 300 11/09/24,11/15/24,11/16/24, I 1000 mg /16/24, and 11/19/24 ne 300 mg tab /16/24, and 11/19/24 20 mg refused 11/09/24, | | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 3 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | |
|--|--|--|--|---|-----------------------------------|--------------------------|
| | | MHL096-277 | B. WING | | 12 | 2/04/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | - | |
| DENILLIE | E EVTENDED INC | 201 WINI | DSOR CREEK PAR | RKWAY | | |
| KENU LIF | E EXTENDED INC | GOLDSE | 3ORO, NC 27530 | | | |
| (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 123 | Continued From page | e 3 | V 123 | | | |
| | and if he was unfamil | se daily. Hose when he was upset | | | | |
| | Interview on 12/04/24 client #7 revealed: -Staff offered medicationsHe refused the medications if he did not want to take them. During interview on 12/04/24 with Medication Tech revealed: -If the client refused the medication, the staff would document it on the MARThe doctor was at the facility "all the time", and the staff would tell her which client refused the medicationShe was aware that all medication refusals had to be documented and an incident report was completed. She was also aware the doctor should be notified of the refusal of the medications. | | | | | |
| | | | | | | |
| | in Charge II revealed: -Medication refusals of electronic record The documentation the incident report and through the electronic -She could not locate #6 and #7She was aware that to be documented and be completed. She wishould be aware of the electronic -She was aware of the should be aware of the electronic -She was aware that the electronic -She was aware -She was a | were documented in the was completed along with d the doctor was contacted c record. the documentation for client all medication refusals had d an incident report was to as also aware the doctor he refusal of medications. e stated that she would | | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 4 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BUILDING: _ | | |
| | | MHL096-277 | B. WING | | 12/04/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | |
| DENILLIE | E EVTENDED INC | 201 WINDS | OR CREEK PA | ARKWAY | |
| KENU LIF | E EXTENDED INC | GOLDSBO | RO, NC 27530 | | |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | | BE COMPLETE |
| TAG | 27G .0603 Incident R 10A NCAC 27G .0603 RESPONSE REQUIFICATEGORY A AND BE (a) Category A and Be implement written poloresponse to level I, II shall require the provice (1) attending to of individuals involved (2) determining (3) developing attended to prevent similar incidence (4) developing attended to prevent similar incidence (5) assigning polorimplementation of preventive measures; (6) adhering to set forth in G.S. 75, Ad 2 CFR Parts 2 and 3 164; and (7) maintaining Subparagraphs (a)(1) (b) In addition to the | esponse Requirements B INCIDENT REMENTS FOR B PROVIDERS I providers shall develop and icies governing their or III incidents. The policies ider to respond by: the health and safety needs if in the incident; the cause of the incident; and implementing corrective to provider specified iteed 45 days; and implementing measures dents according to provider not to exceed 45 days; erson(s) to be responsible the corrections and | | CROSS-REFERENCED TO THE APPROPR | |
| | shall address incident regulations in 42 CFR | s as required by the federal | | | |
| | providers, excluding I develop and impleme their response to a levelop and implementation of the second sec | Rule, Category A and B CF/MR providers, shall nt written policies governing vel III incident that occurs lelivering a billable service | | | |
| | or while the client is o | n the provider's premises. uire the provider to respond | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 5 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE C A. BUILDING: | | | E SURVEY PLETED | |
|---|---|--|---|--|------------------------------|--------------------------|
| | | MHL096-277 | B. WING | | 12 | 2/04/2024 |
| | ROVIDER OR SUPPLIER | 201 WIN | DDRESS, CITY, STATE DSOR CREEK PAR BORO, NC 27530 | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| V 366 | (1) immediately by: (A) obtaining the (B) making a pl (C) certifying th (D) transferring review team; (2) convening a review team within 24 internal review team swho were not involved were not responsible with direct professions services at the time or review team shall confollows: (A) review the confollows: (A) review the confollows: (B) gather othe (C) issue writte within five working dangreliminary findings of LME in whose catchmolocated and to the LM if different; and (D) issue a final owner within three modification of the confollows within three modification in the confollows within three modifications within three modification in the confollows within the confollows | e client record; notocopy; e copy's completeness; and the copy to an internal meeting of an internal hours of the incident. The shall consist of individuals d in the incident and who for the client's direct care or al oversight of the client's f the incident. The internal inplete all of the activities as opy of the client record to nd causes of the incident dations for minimizing the incidents; in preliminary findings of fact by so of the incident. The fact shall be sent to the ment area the provider is E where the client resides, written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues | V 366 | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 6 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE C A. BUILDING: | | | E SURVEY PLETED | |
|---|---|---|----------------------------------|--|------------------------------|--------------------------|
| | | MHL096-277 | B. WING | | 12 | 2/04/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | | |
| RENU LIF | E EXTENDED INC | | DSOR CREEK PAR BORO, NC 27530 | RKWAY | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| V 366 | LME may give the process three months to subsect (3) immediated (A) the LME reconstruction area where the serving Rule .0604; (B) the LME with different; (C) the provided for maintaining and untreatment plan, if different provider; (D) the Department (E) the client's applicable; and | rovider an extension of up to mit the final report; and ly notifying the following: sponsible for the catchment ices are provided pursuant to where the client resides, if the agency with responsibility updating the client's ferent from the reporting | V 366 | | | |
| | failed to ensure Level completed for any methree audited clients are: Finding #1 Review on 12/03/24 revealed: - Date of admission: - Diagnoses of Bilate and partial lobe loboler. | iew and interview, the facility el I incident reports were edication refusals for two of (#6 and #7). The findings of client #6's record 12/12/11. eral subdural hematoma's tomy. a physician or pharmacist refusals/errors from October | | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 7 of 10

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 1 | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------------------|--|--------------------------------|--------------------------|
| | | | A. BUILDING: _ | A. BUILDING: | | |
| | | MHL096-277 | B. WING | | 12 | /04/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, STA | TE, ZIP CODE | | |
| RENU LIF | E EXTENDED INC | | OSOR CREEK PA ORO, NC 27530 | | | |
| (V4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | · | PROVIDER'S PLAN OF C | CORRECTION | (YE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 366 | Continued From page | e 7 | V 366 | | | |
| | Review on 12/03/24 of client #6's medication order dated 09/25/24 revealed: -Ted hose compression stockings applied every morning and removed at night daily at 8:00 (prevent blood clots/circulation). Review on 12/03/24 of client #6's October 2024 thru December 2024 Medication Administration Records (MAR) revealed: -September 20024-Ted Hose refused 09/01/24,09/07/24,09/12/24,09/13/24,09/15/24,09 /16/24,09/24/24 and 09/30/24 - October 2024 - Ted Hose refused 10/01/24,10/11/24,10/12/24,10/13/24,10/14/24,10 /15/24, 10/16/24,10/17/24,10/18/24,10/19/24,10/20/24,10 /21/24,10/27/24,10/30/24 and 10/31/24 November 2024-11/01/24,11/102/24,11/03/24,11/04/24,11/05/24,11/06/24,11/11/24,11/17/24,11/19/24,11/19/24,11/22/24, 11/23/24 and 11/25/24 | | | | | |
| | | | | | | |
| | had been notified of r 2024 to December of | ntia, second to head sphysician or pharmacist efusals/errors for October of 2024. | | | | |
| | orders dated 11/25/24 -Amlodipine Besylate daily (angina), Atorva at bedtime (cholester mg three times daily (| of client #7's medication 4 revealed: 10 mg (milligrams) tablet statin Calcium 20mg tablets ol), Divalproex Sodium 500 (seizures), Fish Oil 1000 mg leart health), Folic Acid 1 mg | | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 8 of 10

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 | |
|---|---|---|---|---|-------------------------------|--|
| | | MHL096-277 | B. WING | | 12/04/2024 | |
| | ROVIDER OR SUPPLIER | 201 WINDS | DRESS, CITY, STA SOR CREEK PA DRO, NC 27530 | ARKWAY | | |
| (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 COMPLET | |
| V 366 | pressure), Lisinopril 2 (hypertension/heart fa 25 mg every evening Oxcarbazepine 300 n (seizures), Quetiapine (mood), Thiamine 100 (nervous system), Vit (microgram) tablet evand nerve cells), Che Check pulse weekly. Review on 12/03/24 of thru December 2024 - October 2024-Divalp 10/22/24, Metoprolol 10/22/24, Quetiapine Fish Oil 1000 mg 10/2 Oxcarbazepine 300 n Atorvastatin 20 mg re-November 2024-Div 11/03/24, 11/12/24/11 Metoprolol Succinate 11/12/24/11/16/24 and 11/19/24, Fish Oil 11/09/24, 11/15/24, 11/1 refused, Oxcarbazepi 11/09/24, 11/15/24, 11/1 refused, Atorvastatin 11/15/24, 11/1 refused, Atorvastatin 11/15/24, 11/1 refused the Ted Hos-He refused the Ted Hos-He refused the Ted Hos-He was unfamiliar with | (cell development), 25 mg tablet daily (high blood 20 mg tablet every morning ailure), Metoprolol Succinate (blood pressure), ng tablet at bedtime 2 300 mg two at bedtime 300 mg tablet every morning amin B-12 1000 MCG ery morning (health blood ck Blood Pressure weekly, of client #7's October 2024 MAR revealed: roex Sodium refused Succinate 25mg refused 300mg refused 10/22/24, 22/24 refused, ng tab 10/22/24 refused, fused 10/22/24. 21/26 and 11/20/24, 25 mg refused 11/03/24, 25 mg refused 11/03/24, 25 mg refused 11/03/24, 21/26, and 11/20/24, Quetiapine 300 11/09/24, 11/15/24, 11/16/24, 11/000 mg 16/24, and 11/19/24 ne 300 mg tab 16/24, and 11/19/24. 20 mg refused 11/09/24, and 11/19/24. 31/26 client #6 revealed: se daily. Hose if he was upset and if | V 366 | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 9 of 10

Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | MHL096-277 | B. WING | | 12/0 | 4/2024 |
| | ROVIDER OR SUPPLIER E EXTENDED INC | 201 WINDS | ORESS, CITY, STA | ARKWAY | | |
| (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 APPROPI DEFICIENCY) | BE | (X5) COMPLETE DATE |
| V 366 | take them. During interview on 1 Tech revealed: -If the client refused to would document it on the doctor was at the staff would tell her whomedicationShe was aware that to be documented an completed. She was abe notified of the refusion of the incident refusals we lectronic recordThe documentation of the incident report aft and the doctor was concluded and the doctor was concluded and the documented a | cations if he did not want to 2/04/24 with Medication the medication, the staff the MAR. e facility all the time, and the nich client refused the all medication refusals had d an incident report was also aware the doctor should sal of the medications. 2/04/24 with the Supervisor were documented in the was completed along with er the medication refusal ontacted through the the documentation for client all medication refusals had d an incident report was also aware the doctor should al of medications. e stated that she would | V 366 | | | |

Division of Health Service Regulation

STATE FORM 6899 QRX711 If continuation sheet 10 of 10