STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	**3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on October 28, 2015. Event ID #CD4H11.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		11/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 Based on record and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately for the behavioral symptoms for 1 of 1 sampled resident. (Resident # 41) Findings Included: Resident # 41 was admitted to the facility on 3/27/2015 with multiple diagnoses including weakness, Dementia, Depression and anxiety. The quarterly MDS assessment dated 10/2/2015 indicated the resident did not have any behavioral symptoms. The resident's record review for the months of September 2015 and October 2015 revealed the resident exhibited behavioral symptoms daily ranging from refusing the Activity of Daily Living(ADLs) to refusing to take her daily meal supplements from the nurses' at the facility. On 10/27/2015 at 9:00 AM, the unit nurse was interviewed. He revealed the resident exhibited behavioral symptoms daily. He also reported the resident was on different medication to help with the behavioral symptoms. On 10/27/2015 at 11:00 AM, the MDS nurse was interviewed. She acknowledged that resident's behavioral symptom should have been coded on the MDS but was missed. She also added that moving forward she will review the resident ' s MDS to make sure the coding is accurate and also reflects the resident's current status. On 10/28/2015 at 10:00 AM, the Director of Nursing(DON) was interviewed. She reported Resident # 41 exhibited daily behavioral	F 278	1. A correction for the MDS coding of behavioral symptoms for Resident #41 will be submitted on 11/20/15. 2. Residents with behavioral symptoms are at risk for this alleged deficient practice. All MDS assessments for residents with behavioral symptoms have been reviewed to identify and correct any errors in coding behavioral symptoms. 3.MDS nurses have been reeducated by the regional MDS nurse concerning the coding of behavioral symptoms according to the RAI manual to include reviewing all the areas of the resident chart and interviewing staff when appropriate for the assessment. The MDS nurses will review and document the review for each MDS for accuracy concerning the coding of behavioral symptoms prior to submission for the next 12 weeks. 4.The MDS nurses will present the results of the review monthly to the QAPI committee for review and recommendations for the duration of the review process and outlined above. 5.Allegation of compliance for this plan is 11/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 symptoms and her expectation was that the MDS should have been coded accurately reflecting the resident behavioral symptoms.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, physician and resident interviews and record review, the facility failed to provide evidence of communication with the dialysis clinic. The facility also failed to monitor the condition of a resident after dialysis treatment and implement safety precautions for a dialysis access site for 1 of 1 (Resident #193) reviewed for dialysis. Findings included: Resident #193 was admitted on 10/10/15 with a diagnosis of end stage renal disease (ERSD) requiring dialysis. The admission Minimum Data Set (MDS) dated 10/17/15 still in progress indicated Resident #193 was cognitively intact and extensive assistance with his activities of daily living except for eating which required supervision. Resident #193 was care planned for dialysis Tuesday, Thursday and Saturday with interventions to include monitoring the shunt/vascular/catheter access for sign and symptoms of bleeding or infection, assessment of	F 309	1. Information concerning resident #193's treatment on 10/27/15 by the dialysis center was gathered by the Director of Nursing and documented in the resident's chart. Staff was notified of restrictions for vital signs and assessment was completed for the resident. The kardex located on the inside of the resident's closet has been updated to state the limitations due to the presence of the shunt/ fistula. The resident assessment was completed. 2. Residents receiving hemodialysis are at risk for these issues. Each resident on hemodialysis has an assessment every shift of the shunt/ fistula/ port that is used for the dialysis. The assessment is located on the MAR. The kardex for hemodialysis residents is kept on the inside of the closet door for referral by all	11/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 the access site for a thrill or bruit as ordered, monitoring lung sounds for edema, vital signs as ordered and communication with the dialysis staff and physician as per routine. A review of the hospital stay for Resident #193 indicated he had an arterial/vascular fistula procedure done June 2015 in preparation for dialysis. He was admitted to the hospital on 9/24/15 in acute renal failure and had a Permcath (intravenous access used for dialysis) placed. During his first dialysis treatment, Resident #193 went into cardiac arrest with cardio-pulmonary resuscitation (CPR) given. He was admitted to the facility on 10/10/15 with orders for dialysis 3 times weekly. In an interview on 10/26/15 at 11:00 AM, Resident #193 stated he had a fistula in his right lower arm that was maturing and the Permcath to his right chest was temporary. He stated the facility had not drawn any labs since his admission and he told the staff not to take is blood pressure in his right arm. He stated he thought the staff would have known that he couldn ' t have anything constricting his right arm. In an interview on 10/27/15 at 9:00 AM, Nurse #1stated she would assess his vital signs and look at the catheter to make sure it was intact every time she worked with him. She stated she was aware Resident #193 had a fistula to his right arm and he could not have any blood draws from that arm. On 10/27/15 at 9:30 AM, Resident #193 left the facility for his dialysis treatment. In his closet was a kardex with instructions for caring for a resident no longer residing in Resident #193 ' s room.	F 309	nursing staff indicating that the resident is on dialysis treatment and the location of the shunt/ fistula/ port that is used for dialysis. There will be a clear statement concerning limitations for the limb with the fistula. Dialysis communication form Med Pass CP1697 is now being used for communication between the building and the dialysis center with each visit. The resident will be assessed prior to discharge using the Saber Departure/ Return from dialysis Assessment in Point Click Care. The resident will be assessed upon return using the Saber Departure/ Return from Dialysis Assessment and the information will also be placed on form CP1697. Any change of condition noticed during either pre or post dialysis assessments will be called to the physician. 3. The nursing staff has been in-serviced concerning the above information by the Director of Nursing or Unit Manager. The kardex for all hemodialysis residents have been verified for complete information. New admissions on hemodialysis will have the kardex verified during the admission process by the director of nursing or designee. The communication forms used for dialysis from the previous day will be brought to the next at risk meeting for review. The chart will be checked for the completion of the Saber Departure/ Return assessment. Any information missing will be gathered and documented. The nurse responsible identified for follow-up.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 In an interview on 10/27/15 at 2:00 PM, unit manager #1 stated there was a communication assessment form that should be completed after each dialysis treatment but she was only able to produce a form dated 10/27/15 created at 1:10 PM with vital signs documented as taken earlier in the shift. Unit manager #1 also stated she had no documentation of communication between the dialysis clinic and the facility regarding any of his dialysis treatments. Unit manager #1 stated the only way anyone would know anything about his dialysis treatment would be if she asked Resident #193 or called the dialysis clinic. In an interview on 10/27/15 at 2; 10 PM nursing assistant (NA) #1 stated she had worked at the facility for 2 and one half years and she was familiar with Resident #193. NA #1 stated she was not aware of any need to obtain vital signs after his treatments or was she aware that Resident #193 had a fistula in his right arm. She stated the residents had instructions about their care in their closets In another interview on 10/27/15 at 2:30 PM, Nurse #1 stated she worked at the facility for two and one half years and the nurses were responsible for putting the kardex forms with precautions on each resident closet. She verified Resident #193 had no information inside his closet directing the staff in care precautions. In an interview on 10/27/15 at 2:40 PM, the medical director stated the facility should be in communication with the dialysis clinic if there was any problems with Resident #193 during his treatment and he should be thoroughly assessed including his vital signs and his vascular access	F 309	4.The Director of Nursing will document this process each At Risk meeting x 4 weeks, 3x a week for 4 weeks, and then weekly x 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process. 5.Allegation of compliance is 11/20/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5	F 309		

after each treatment to ensure he was stable since his had a history of a recent cardiac arrest associated with his dialysis treatment. The medical director further stated his expectation that the facility know the proper precautions required when caring for a dialysis resident.

In an interview on 10/27/15 at 2:50 PM, NA #2 stated she had worked at the facility for two and one half years and she was assigned Resident #193 today. She stated she took his vital signs before he went to his dialysis treatment this morning. She stated Resident #193 arrived back from dialysis around 2:45 PM. NA #2 stated she did not obtain his vital signs on his return and he went straight to therapy. NA #2 also stated he normally does not get back on her shift but rather on second shift. NA #2 stated she was unaware that Resident #193 had a fistula in his right arm and not aware his blood pressure should not be obtained in his right arm.

In an interview on 10/27/15 at 3:40 PM, Resident #193 stated nobody had obtained his vital signs since yesterday or assessed him since he got back from dialysis today. He stated she went straight to therapy then to bed because he felt really tired.

In an interview on 10/27/15 at 4:00 PM, administrator, director of nursing and nurse consultant stated the facility had no policy or procedure for caring for dialysis residents. The nurse consultant also stated there was no communication between the facility and the dialysis clinic.

In an interview 10/27/15 at 4:10 PM Nurse #2 stated she had not assessed Resident#193 yet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 but she check on him when she after he got back from therapy. She stated she started her medication pass and did not obtain his vital signs as of yet. In an another interview on 10/28/15 at 8:30 AM, Resident #193 stated they got his vital signs yesterday and they put up a sign in his room informing staff not to do lab draws or blood pressure in his right arm. He stated they asked his permission before putting up the sign and he felt a lot better knowing it was up there. The Permcath was observed with the caps secured with tape. In an interview on 10/28/15 at 10:40 AM, the rehabilitation director stated Resident #193 came straight to therapy yesterday and stood for 6 minutes before tiring. She stated therapy did not assess his vital signs or access prior to therapy. In an interview 10/28/15 at 11:40 AM the nurse consultant and the administrator stated their expectation would be for the facility staff know how to adequately care for a dialysis resident to include access safety and precautions, clinical assessment and have communication with the dialysis clinic.	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		11/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 7 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post daily staffing with the resident census and the actual hours worked of registered nurse (RN) separate from the actual hours worked by licensed practical nurse (LPN) for 4 of 4 days of the survey. The findings included: On 10/25/15 at 4:30 PM, during the initial tour, the posting of daily staffing included the total actual hours worked by all licensed nurse (RN and LPN) by shift. The posting did not list separately the	F 356	1.The form was updated to include the separate hours of Registered nurses and Licensed Practical Nurses worked and the total census as soon as the issue was brought forward. 2.The incomplete form has been replaced with a forms with the following information: Facility name, Current date, the total number and actual hours worked by direct care staff who are Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants, and Resident Census	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 8 actual hours worked by RN and LPN. The daily staffing did not include the resident census. On 10/26/15 at 8:00 AM, the posting of daily staffing included the total actual hours worked by all licensed nurse (RN and LPN) by shift. The posting did not list separately the actual hours worked by RN and LPN. The daily staffing did not include the resident census. On 10/27/15 at 8:00 AM, the posting of daily staffing included the total actual hours worked by all licensed nurse (RN and LPN) by shift. The posting did not list separately the actual hours worked by RN and LPN. The daily staffing did not include the resident census. On 10/28/15 at 8:00 AM, the posting of daily staffing included the total actual hours worked by all licensed nurse (RN and LPN) by shift. The posting did not list separately the actual hours worked by RN and LPN. The daily staffing did not include the resident census. Interview with the Director of Nursing on 10/28/15 at 9:45 AM revealed that she followed the same format on the form that was completed in the past. Interview with the Administrator on 10/28/15 at 9:50 AM revealed that she was not aware that the form did not list the actual hours worked by the registered nurse separate from the licensed practical nurse hours worked. The Administrator further stated that going forth she would make sure the form is revised and it captures the daily resident census and the actual hours worked by registered nurse separate from the hours worked by the licensed practical nurse.	F 356	3. The nursing staff has been reeducated to complete the form appropriately and to post daily by the Director of Nursing or Unit Manager. 4. The Administrator will monitor the posting each morning meeting and document it daily x 2 weeks and then weekly x 4 weeks. The Administrator will report the findings to the monthly QAPI committee for review and recommendations for the duration of the monitoring. 5.The Allegation of Compliance Date for this plan is 11/20/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	**3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE