STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G152	A. BUILDING _____ B. WING _____	08/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1000 NEWTON STREET NE WASHINGTON, DC 20019

(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
W 000	INITIAL COMMENTS A recertification survey was conducted from August 16, 2010, through August 17, 2010, utilizing the fundamental survey process. A sample of two clients was selected from a population of two females with various levels of mental retardation and disabilities. A focus was conducted on one client who was discharged from the facility on May 3, 2010. The findings of the survey were based on observations at the group home and one day program, interviews with clients and staff, and the review of clinical and administrative records, including incident reports.	W 000	Received 9/2/10 DOH-HRLA-ICFD	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) for one discharged client. (Client #3) The finding includes: Review of an incident report dated April 12, 2010 and an investigative report dated April 15, 2010,	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Johnson Mackins	Adm. Asst.	9/2/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 on August 18, 2010 at 9:35 a.m., revealed Client #3 sustained a physical injury above her right eye on the morning of April 12, 2010. According to the incident report, Client #3 was hit in the face by another client while riding on the facility's van. Review of Client #3's hospital "Discharge Instructions" dated April 12, 2010, revealed the client's diagnoses included right frontal hematoma closed head injury (CHI) and hypokalemia. Further review revealed the client was evaluated, treated and released to the group home on the same day During a face to face interview with the Qualified Mental Retardation Professional (QMRP) on August 16, 2010 at approximately 10:00 a.m., it was acknowledged the allegation of client to client abuse was not sent to the Department of Health (DOH) until July 22, 2010. There was no evidence the facility ensured the timely notification of all allegations of abuse or actual harm was conducted as required by this regulatory requirement to the Department of Health (DOH).	W 153	**W 153** **Staff will be trained on incident management policies and procedures.** **The facility's Incident Management Coordinator (IMC) will work with the House Manager in ensuring that all incidents are reported to the necessary authorities in a timely manner.**	09.30.10 09.30.10
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the	W 156		

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W 156	Continued From page 2 incident for one discharged client. (Client #3) The finding includes: Review of an incident report dated April 12, 2010 on August 18, 2010, at approximately 9:35 a.m., revealed Client #3 sustained a physical injury above her right eye after being hit by another client while riding in the facility's van. Review of Client #3's hospital "Discharge Instructions" dated April 12, 2010, revealed the client's diagnoses included a right frontal hematoma, closed head injury (CHI) and hypokalemia. Review of the corresponding investigative report dated April 15, 2010, on August 20, 2010 at approximately 1:35 p.m., revealed that the Qualified Mental Retardation Professional (QMRP) completed the investigation on April 21, 2010. Further review revealed the administrator reviewed and signed the investigative report on April 22, 2010. During a telephone interview with the QMRP on August 20, 2010, at approximately 2:30 p.m., it was acknowledged the administrator reviewed and signed the investigative report on April 22, 2010. There was no documented evidence the facility reported the results of all investigations to the administrator within five working days of the incident.	W 156	**W 156** **The facility will adhere to completing and reporting the investigation report within five working days in accordance with State Law.** **The facility's Incident Management Coordinator (IMC) will work closely with the Assistant Administrator in ensuring that all investigations are completed and reported to the administrator within five working days.**	09.30.10
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each employee was effectively trained enabling them to perform their duties effectively, efficiently, and competently for three (3) of sixteen (16) staff. The findings include: 1. The facility failed to ensure that the Direct Care Staff (DCS) had received effective training on Client #1's mealtime guidelines as evidenced by: During breakfast observation on August 16, 2010, at approximately 7:30 a.m., staff was observed to feed Client #1 chopped eggs, hash brown potatoes and toast with a slightly built -up spoon from a high sided plate. During a face to face interview with the direct care staff on August 16, 2010 at approximately 8:00 a.m., it was acknowledged Client #1 was capable of feeding herself. Review of Client #1's mealtime guidelines dated March 2010 on August 17, 2010, at approximately 11:00 a.m., revealed the client eats independently after set up with close supervision and assistance to decrease distractibility and to maintain a safe rate of food intake. There was no visible evidence that the facility staff allowed the client to eat independently according to her mealtime guidelines.	W 189	**W 189, 1** **The speech and language pathologist will train staff on client#1's mealtime guidelines.** **The facility's House Manager will on a weekly basis observe staff in implementing client#1's mealtime guidelines.** **A memo will be sent to all staff reminding them about not to feed client#1 during meals.**	09.30.10

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W 189	Continued From page 4 2. Cross Refer to W153. The facility failed to ensure the Qualified Mental Retardation Professional (QMRP) had received effective training on their incident management policy to ensure the timely notification of all allegations of abuse to the Department of Health/Health Regulation Licensure Administration (DOH/HRLA). 3. Cross Refer to W156. The facility failed to ensure the QMRP had received effective training on their incident management policy to ensure the facility reported the results of all investigations to the administrator within five working days of the incident. 4. Cross Refer to W252. The facility failed to ensure that the DCS had received effective training on data collection to make certain all required targeted behaviors were captured.	W 189	**W 189, 2** **The Qualified Mental Retardation Professional (QMRP) will be re-trained on incident management policies and procedures. The training will emphasize timely completion and submission of investigative report to the Department of Health, and the facility's administrator.** **W 189, 3** **Cross Reference W 156.** **W 189, 4** **Please refer to W 252**	09.30.10 09.30.10
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff was effectively trained to implement a client's behavior management plan, for one of two clients included in the sample. (Client #1) The finding includes: During medication observation on August 16, 2010, at approximately 8:10 a.m., Client #1 was observed licking the surface of the dining room	W 193		

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W 193	Continued From page 5 table four (4) times. The Acting House Manager made no attempt to redirect the behaviors. During a face to face interview with the Acting House Manager on August 16, 2010, at approximately 8:15 a.m., revealed Client #1 had a behavior support plan to address her targeted behaviors that included surface licking. Further interview revealed the Acting House Manager did not implement the client's BSP. Review of Client #1's BSP dated March 28, 2010, on August 17, 2010 at approximately 12:10 p.m., revealed Client #1's BSP listed surface licking and finger licking as two of her targeted maladaptive behaviors. The BSP revealed if the client engages in surface licking her name was to be called, eye contact established and in a firm tone of voice say "stop, client #1 ". There was no evidence the facility ensured all staff was effectively trained specifically on Client #1's behavior management plan.	W 193	**W 193** **Staff will be re-trained on client #1's Behavior Support Plan (BSP).** **The House Manager and QMRP will on a weekly observe staff implementation of the interventions specified in client#1's BSP.** **Hands on training will be provided to a staff who does not implement the interventions specified in client #1's BSP.**	09.30.10
W 201	483.440(b)(4)(i) ADMISSIONS, TRANSFERS, DISCHARGE If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure documentation in the client's record that the client was transferred or discharged for good cause for one of one client discharged from the facility. (Client #3)	W 201		

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W 201	Continued From page 6 The finding includes: During a face to face interview with the Qualified Mental Retardation Professional (QMRP) on August 16, 2010, at approximately 10:05 a.m., it was acknowledged that Client #3 was discharged from the facility on May 3, 2010, in the custody of her Mother. Further interview revealed that Client #3's medical records were not in the facility. There was no documented evidence at the time of the survey that the client was transferred or discharged for good cause.	W 201	**W201** **Resident #3's transfer was an emergency case (not a good cause situation). Her mother took her away from the facility after an incident and refused to bring her back. After several failed attempts by the facility in getting Resident #3 back to the facility, an emergency discharge was held with the mother and the Department on Disability Services (DDS) on May 3rd, 2010.** **The facility's policy on maintaining records after discharge of a resident, states; "Upon discharge of a resident, all habilitation record shall be transferred to the administrative office..." At the time of the survey, resident #3's records were stored in the administrative office as per company's policy.**	05/03/10
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for one of the two clients in the sample. (Client #1) The finding includes: Review of Client #1's dental consult dated February 1, 2009, on August 17, 2010, recommended the client brush her teeth two (2)	W 242		

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W 242	Continued From page 7 to three (3) times a day. Further review of Client #1's dental consultations dated June 18, 2009 and July 27, 2009 on August 17, 2010, at approximately 9:10 a.m., revealed plaque and calculus was present on all of the client's remaining teeth. Review of Client #1's Individual Program Plan (IPP) dated August 2010, on August 17, 2010 at approximately 9:12 a.m., revealed no evidence of a training program to address the client's oral hygiene. During a face to face interview with the Licensed Practical Nurse #4 (LPN #4) on August 17, 2010, at approximately 1:20 p.m., acknowledged Client #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the client's IPP included training in activities of dental hygiene.	W 242	**W 242** **A formal Individual Program Plan (IPP) will be put in place to enhance client #1's participation in tooth brushing tasks.** **The implementation of the IPP will be monitored quarterly by the QMRP and the facility's Registered Nurse (RN) for progress.**	09.01.10
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the two clients in the sample. (Client #1) The finding includes:	W 252		

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W 252	Continued From page 8 During medication observation on August 16, 2010, at approximately 8:10 a.m., Client #1 was observed licking the surface of the dining room table four (4) times. Review of Client #1's BSP dated on March 28, 2010, on August 17, 2010 at approximately 12:10 p.m., revealed Client #1's listed surface licking and finger licking as two of her targeted maladaptive behaviors. The BSP revealed if the client engages in surface licking her name was to be called, eye contact established and in a firm tone of voice say "stop, client #1 ". According to the data collection instructions, staff were to record all incidents of targeted behaviors on the Antecedent Behavior Consequence (ABC) sheet. Review of the ABC data sheet on August 17, 2010, at approximately 12:10 p.m., revealed Client # 1 had no maladaptive behaviors documented on August 16, 2010, at 8:10 a.m. During a face to face interview with Licensed Practical Nurse #4 (LPN #4) on August 17, 2010, at approximately 12:30 p.m., it was acknowledged the staff had not documented the aforementioned maladaptive behavior on the ABC date sheet. There was no evidence that data had been collected in accordance with the client's BSP.	W 252	**W 252** **Staff will be trained on client#1's Behavior Support Plan and data collection.** **The House Manager and QMRP will on a weekly basis observe staff implementation of interventions specified in client #1's BSP and also monitor consistency in data collection.**	09.30.10

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I 000	INITIAL COMMENTS A relicensure survey was conducted from August 16, 2010 thru August 17, 2010. Two residents was selected from a resident population of two females with various degrees of disabilities. A focus was conducted on one resident who was discharged from the facility on May 3, 2010. The findings of this survey were based on observations at the group home and one day program, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner for two of two residents in the facility. (Resident #1, and #2) The findings include: Observation and interview with the facility's Qualified Mental Retardation Professional (QMRP) on August 16, 2010, beginning at 9:20 a.m. revealed the following: Interior: 1. The light near the second floor of the GHMRP	I 090		

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I 090	Continued From page 1 exit door did not have a light cover. Exterior 2. The second floor exit door of the GHMRP had chipping and peeling paint on the outside of the door. 3. The wood railing, on the front porch of the GHMRP had nails protruding outwards creating the potential of injury of hands. 4. The wood planks on the front porch of the GHMRP were raised upward creating the potential for injury by someone tripping on the planks. During a face-to-face interview on August 16, 2010, at approximately 10:00 a.m., the Qualified Mental Retardation Professional acknowledged the findings.	I 090	**I 090, 1** **The light cover has been installed.** **I 090, 2** **The second floor exit door has been re-painted.** **I 090, 3** **The protruding nails have been covered by protective wares so as to avoid potential injury.** **I 090, 4** **The whole porch will be remodeled so as to eliminate potential for injury.** **Once monthly, the facility's maintenance team will conduct internal and external environmental audits so as to enhance a clean and safe environment.**	**09/30/10**
I 192	3508.8(c) ADMINISTRATIVE SUPPORT Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts: (c) Professional Liability This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review, professional liability insurance for one of twelve professionals. (Pharmacist) The finding includes:	I 192		

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I 192	Continued From page 2 Review of personnel records on August 16, 2010, at approximately 11:40 a.m., revealed the GHMRP failed to prDvide evidence of professional liability insurance for the pharmacist . In an interview with the Qualified Mental Retardation Professional (QMRP) on August 16, 2010, at approximately 2:00 p.m., it was acknowledged that the pharmacist did not have professional liability insurance certificates on file. There was no evidence the facility had professional liability insurances DN file fDr all professionals.	I 192	**I 192** **The pharmacist has submitted a professional liability insurance.** **The facility's Human Resource Personnel will on a monthly basis conduct review of consultants' files to ensure that all required documents are current or updated as needed.**	**09/30/10**
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP)'s nursing staff failed to demonstrate competency in the implementation of the Behavior Support Plan (BSP), for one of two residents included in the sample. (Resident #1) The finding includes: During medication observation on August 16, 2010, at approximately 8:10 a.m., Resident #1 was observed licking the surface of the dining room table four (4) times. The Acting House	I 229		

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I 229	Continued From page 3 Manager made no attempt to redirect the behaviors. During a face to face interview with the Acting House Manager on August 16, 2010, at approximately 8:15 a.m., revealed Resident #1 had a behavior support plan to address her targeted behaviors that included surface licking. Further interview revealed the Acting House Manager did not implement the resident's BSP. Review of Resident #1's BSP dated on March 28, 2010, on August 17, 2010 at approximately 12:10 p.m., revealed Resident#1's listed surface licking and finger licking as two of her targeted maladaptive behaviors. The BSP revealed if the resident engages in surface licking her name was to be called, eye contact established and in a firm tone of voice say "stop, [Resident#1] ". There was no evidence the facility ensured all staff was effectively trained specifically on Resident #1's behavior management plan.	I 229	**I 229** **All staff (including the Assistant House Manager) will be re-trained on Resident #1's BSP.** **The House Manager and the QMRP will on a weekly basis conduct random observations of staff implementing Resident #1's BSP.**	**09/30/10**
I 355	3518.4(a) DISCHARGE / TRANSFER POLICIES PROCEDURES Each GHMRP shall plan for voluntary or involuntary transfer or discharge of a resident on a non-emergency basis and shall provide the following: (a) Sixty (60) days notification to appropriate individuals or sponsoring agencies of reasons for the need to transfer or discharge; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide evidence of notification to	I 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0128	A. BUILDING _____ B. WING _____	08/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1000 NEWTON STREET NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 355	Continued From page 4 appropriate individuals or sponsoring agencies of the reason for the need to transfer one of one resident discharged from the facility. (Resident #3) The finding includes: During a face to face interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on August 16, 2010 at approximately 10:05 a.m. it was acknowledged that Resident #3 was discharged from the facility on May 3, 2010, in the custody of her Mother. Further interview revealed that Resident #3's medical records were not in the facility. There was no documented evidence at the time of the survey that the resident was transferred or discharged for good cause.	I 355	**I 135** **I 355 is applicable to a <u>non-emergency transfer</u>. Resident #3's transfer was an emergency case. Her mother took her away from the facility after an incident and refused to bring her back. After several failed attempts by the facility in getting Resident #3 back to the facility, an emergency discharge was held with the mother and the Department on Disability Services (DDS) on May 3rd, 2010.** **The facility's policy on maintaining records after discharge of a resident, states; "Upon discharge of a resident, all habilitation record shall be transferred to the administrative office..." At the time of the survey, resident #3's records were stored in the administrative office as per company's policy.**	05.03.10
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure unusual incidents that interfered substantially with the resident's health was	I 379		

STATEMENT DF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 379	Continued From page 5 reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for one discharged resident. (Resident #3) The finding includes: Review of an incident report dated April 12, 2010 on August 18, 2010 at approximately 9:35 a.m., revealed Resident #3 sustained a physical injury above her right eye on the morning of April 12, 2010. According to the incident report, Resident #3 was hit in the face by another resident while riding on the facility's van. Review of Resident #3's hospital "Discharge Instructions" dated April 12, 2010, on August 20, 2010 at approximately 1:35 p.m., revealed the client's diagnoses included a right frontal hematoma, closed head injury (CHI) and hypokalemia. Further review revealed the resident was evaluated, treated and released to the group home on the same day During a face to face interview with the Qualified Mental Retardation Professional (QMRP) it was acknowledged the allegation of resident to resident abuse was not sent to the Department of Health (DOH) until July 22, 2010. There was no evidence the facility ensured the timely notification of all allegations of abuse or actual harm was conducted as required by this regulatory requirement to the Department of Health (DOH).	I 379	**I 379** **Staff will be trained on incident management policies and procedures. Emphasis of the in-service will be timely notification of regulatory agencies of an incident.** **The facility's Incident Management Coordinator (IMC) will ensure compliance with incident management policy through tracking and trending of when incidents are reported to regulatory agencies and the administrative office.**	09/30/10
I 432	3521.7(c) HABILITATION AND TRAINING	I 432		

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I 432	Continued From page 6 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure the residents had training on brushing their teeth, for one of one resident in the sample. (Resident #1) The finding includes: Review of Resident #1's dental consult dated February 1, 2009, on August 117, 2010 recommended the resident brush her teeth two (2) to three (3) times a day. Further review of Resident #1's dental consultations dated June 18, 2009 and July 27, 2009 on August 17, 2010, at approximately 9:10 a.m., revealed plaque and calculus was present on all of the residents remaining teeth. Review of Resident #1's Individual Program Plan (IPP) dated August 2010, on August 17, 2010 at approximately 9:12 a.m., revealed no evidence of a training program to address the client's oral hygiene. During a face to face interview with the Licensed Practical Nurse #4 (LPN #4) on August 17, 2010, at approximately 1:20 p.m., acknowledged Resident #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the resident's IPP included training in activities of	I 432	**I 432** **A formal Individual Program Plan (IPP) will be put in place to enhance resident #1's ability to brush her teeth.**	09.01.10

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I 432	Continued From page 7 dental hygiene.	I 432		