

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
A 000	Initial Comments A Complaint Investigation #2022007432 was conducted on Silver Creek Assisted Living St. Cloud had deficiencies at the time of the survey.	A 000		
A 093 SS=G	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.frlrules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://lcom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed	A 093		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER SILVER CREEK ASSISTED LIVING ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772		
(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) COMPLETE DATE
A 093	Continued From page 1 nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
A 093	Continued From page 2 notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to prepare and serve a therapeutic diet as ordered by a health care provider and failed to follow its puree menu for 1 of 4 sampled residents (#1).	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER SILVER CREEK ASSISTED LIVING ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772		
(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) COMPLETE DATE
A 093	Continued From page 3 Findings: Resident #1's record revealed a facility admission date of _____. An 1823 health assessment form, dated _____, indicated the resident's diagnoses were _____, _____, and _____. The form also indicated the resident was bedridden and required total assistance with all activities of daily living (ADLs), including eating. The diet section on the form was not completed. Review of hospice documentation revealed the resident was admitted to hospice services on _____. Review of a speech _____'s evaluation, dated _____, revealed documentation that indicated the evaluation was conducted due to increased coughing during meal consumption. Recommendations at that time were a mechanical soft diet texture and nectar thickened liquids. Review of an "IDG meeting review" hospice document that was electronically signed by a health care provider on _____, revealed documentation that indicated the resident's diet was puree with thickened liquids. A hospice visit note, dated _____, indicated the resident had swallowing _____ and that his diet consistency was puree. Review of a facility incident report revealed documentation that indicated that on _____ at approximately 7:45 a.m., caregiver A prepared pancakes for the resident. At 8:20 a.m., the caregiver began feeding the resident. At 8:23	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER SILVER CREEK ASSISTED LIVING ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772		
(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) COMPLETE DATE
A 093	Continued From page 4 a.m., the caregiver yelled for help, the administrator ran into the resident's room and saw the resident choking. The administrator initiated () then called 911. Paramedics arrived by 8:26 a.m. and took over care of the resident. The administrator provided the paramedics with a copy of the resident's () at which time, the paramedics stopped life saving measures. The resident was pronounced () by 8:30 a.m. The facility's analysis (apparent cause) of the incident was that when the resident took a second bite of the pancakes with syrup, he began choking because he had just woken up and was not totally awake. On () at 12:04 p.m., caregiver A said that on () at approximately 7 a.m., she woke resident #1 up then cleaned and changed him. At approximately 7:15 a.m., the caregiver prepared the resident's breakfast of pancakes and syrup which, she said, made the pancakes soggy. The caregiver said the resident ate that for breakfast every day. The caregiver said she cut the pancakes into small pieces. She said the resident swallowed his first bite without difficulty. She said when the resident took his second bite, he began coughing then looked as if he could not breath. She ran to get the administrator, who accompanied the caregiver to the resident's room. The caregiver () the resident on his () but he was still gasping for air. The caregiver tried pushing on the resident's () to see if that would help. The resident then became unresponsive. The caregiver said the 911 operator instructed her to perform () but the resident wasn't responding. She said then emergency personnel arrived. The caregiver said she normally fed the resident soft foods such as mashed potatoes, mashed up macaroni and	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
A 093	Continued From page 5 cheese, and pureed fish. When asked by the surveyor if she understood what a puree diet was, the caregiver responded that she was not sure what pureed consistency was. She said at times she used a food processor, which made the food consistency similar to that of baby food. She said the resident had a hospital bed and she placed the _____ of the bed in an upright sitting position before she fed him. The caregiver said the resident appeared sleepy but, was also looking around. The caregiver said the resident did not have any _____. She said there was one previous time when the resident coughed, and his _____ turned red during a meal. On _____ at 1:24 p.m., caregiver B said that when she previously fed the resident, he coughed at times so she took her time feeding him and gave him something to drink. The caregiver said "anything that was hard, such as meat" she pureed it in the food processor. She said the resident enjoyed pancakes and _____ cereal for breakfast. She said she cut the pancakes into small pieces then poured syrup on them. Review of the facility's pureed breakfast menu, signed by a registered dietician and dated _____, revealed items on the menu were soft poached egg and soft cooked cereal. On _____ at 1:28 p.m., the registered dietician who signed the pureed menu said the facility should only prepare and serve those items listed on the pureed menu. She said foods such as breads and pancakes, when pureed, tend to become balls, and stick to the roof of the resident's _____ and therefore, should be _____. On _____ at 1:33 p.m., the surveyor showed the	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
A 093	Continued From page 6 pureed menu to caregiver B, who said she'd never seen it before. On _____ at 1:53 p.m., the administrator said that on _____ at approximately 7 a.m., she was in the kitchen preparing breakfast. She said caregiver A approached her and said that resident #1 only stared at her when she asked if he wanted to eat. The administrator said caregiver A then asked the administrator to help sit the resident up. The administrator said the resident's _____ were closed and she asked him how he was doing. She said the resident then opened his _____ and smiled at her. She then asked him if he wanted to eat, and he replied that he did. The administrator said caregiver A then prepared the resident's pancakes and a short time later, the caregiver called out and said the resident was choking. The administrator responded to the resident's room and saw the resident was sitting up in bed. She and caregiver A _____ the resident on his _____. The administrator called hospice but was unable to get anyone. She then called 911. She and the caregiver used the bed sheet to place the resident onto the floor. They began _____. Emergency personnel arrived then took over the resident's care. The administrator said the resident's diet was puree. She said his pancakes were cut into small pieces and syrup was poured on them. She said the resident's diet was changed to puree because he started coughing when he ate. When asked by the surveyor why soft poached egg or cooked cereal was not given to the resident, as it indicated on the puree menu, the administrator said, "we tried different things for him to enjoy". She said the resident most enjoyed pancakes and would not eat other things. On _____ at 2:10 p.m., caregiver A said she was	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
A 093	Continued From page 7 aware of the puree breakfast menu then said she did not follow it and gave the resident pancakes instead because the resident liked them more than anything else. On at 2:12 p.m., the administrator said regarding the incident with resident #1, "I believe he was not truly awake. When he was awake, he was alert, smiling. I believe, in my , that he was not truly awake." Class II	A 093		
CZ841 SS=D	408.823() FS In-person Visitation (1) This section applies to centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than	CZ841		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER CREEK ASSISTED LIVING ST CLOUD

**2910 OLD CANOE CREEK ROAD
SAINT CLOUD, FL 34772**

(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) COMPLETE DATE
CZ841	Continued From page 8 those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery.	CZ841		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER SILVER CREEK ASSISTED LIVING ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772		
(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) COMPLETE DATE
CZ841	Continued From page 9 8. patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on review of the facility's visitation policy and procedures, review of the facility's website, and interview, the facility failed to ensure its policy contained designation of a person responsible for ensuring that staff adhere to the policies and procedures and failed to make its policy easily accessible from the homepage of its website. Findings: Review of the facility's undated visitation policy and procedures revealed it did not contain designation of a person responsible for ensuring that staff adhere to the policies and procedures. Review of the facility's website on at 11:15 a.m. revealed the policy was not made available on the homepage. The administrator confirmed the findings.	CZ841		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER SILVER CREEK ASSISTED LIVING ST CLOUD		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772			
(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) COMPLETE DATE
CZ841	Continued From page 10 Class III	CZ841			