STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026048	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 02/01/23 - 02/02/23.	D 000	Hot water heater Were fixed While survey team was in the building - Water temperature logs will be completed weekly with recorded on Log. Maintenace is responsible for recording temps - And reporting of any Veriation Of temps - Temper should not below 100 and not exceed. 116 - maintenance will be responsible for reporting to owner	02/02/23 ww
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 4 of 4 fixtures sampled that were readily accessible and used by residents with water temperatures ranging from 126.9 degrees F to 132.4 degrees F. The findings are: Review of the facility's census reports provided on 02/01/23 revealed the facility's in-house census was 41 residents. Correction number of Residents (21) Review of the North Carolina Division of Health Service Regulation Construction Section hot water safety issues revealed: -A water temperature of 120 degrees Fahrenheit (F) could result in a first degree burn in 8 minutes	D 113		

The plan of correction with addendum was reviewed and acknowledged 03/21/23. Refer to addendum on pages 2, 5, 7, and 10 of this Statement of Deficiencies.
Wendy Williams 03/21/23

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D 113	Continued From page 1 and a second degree burn in 10 minutes. -A water temperature of 125.6 degrees F could result in a first degree burn in 45 seconds and a second degree burn in 1.5 minutes. -A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. Review of the facility's weekly temperature log on 02/01/23 revealed the water temperatures in the women's bathroom in January 2023 ranged from 123.7 degrees F to 125.2 degrees F. Review of the facility's weekly temperature log on 02/01/23 revealed the water temperatures in the men's bathroom in January 2023 ranged from 123.4 degrees F to 125.1 degrees F. Observation of the women's bathroom on 02/01/23 at 9:17am revealed the water temperature in two bathroom sinks was 132.4 degrees F. Observation of the men's bathroom on 02/01/23 at 9:22am revealed the water temperature in two bathroom sinks was 126.9 degrees F. Interview with the Maintenance Director on 02/01/23 at 9:46am revealed: -He was responsible to ensure the water temperature was between the minimum and maximum temperature (100 degrees F- 116 degrees F). -He checked water temperatures weekly. -The last time he checked the water temperature, it was outside of the maximum temperature. -He had a plumber come to the facility (not sure of date) and he did something to fix the water temperature. -The plumber told him to give the water	D 113	D113 - Addendum per telephone conversation with Mr. Gedarin Robinson, Administrator on 03/21/23 : The Facility Manager will monitor water temperature logs monthly to ensure compliance. The correction date is 2/3/23. -Wendy Williams 03/21/23	

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D 113	Continued From page 2 temperature some time to readjust. -The plumber did not specify how long to allow the water temperature to readjust. Interview with the plumber on 02/01/23 at 1:20pm revealed: -He had been out to the facility often related to other problems as well as the water temperature (not sure of dates). -Today, 02/01/23, the thermostat on the water heater malfunctioned and he had to replace it. Telephone interview with a representative from the plumbing company on 02/02/23 at 10:50am revealed the company repaired the water temperature heater lines and repaired the thermostat on the water heater on 12/29/22. Interview with the Administrator on 02/02/23 at 9:56am revealed: -He was made aware of the water temperature yesterday (02/01/23). -He expected staff to notify him immediately when the water temperature was outside of the maximum temperature. Interview with the Owner on 02/01/23 at 9:59am revealed: -She had trouble with the water for the last month. -She was not aware of the water temperature being that far out of range. -She expected the Maintenance Director to notify her the water temperature was outside of the maximum temperature, check water temperature, and adjust the water temperature before calling a plumber. The facility failed to ensure hot water temperatures for 4 of 4 fixtures sampled in the	D 113		

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D 113	Continued From page 3 facility that were used by residents were maintained between 100- 116 degrees F. A water temperature of 120 degrees F could result in a first degree burn in 8 minutes and a second degree burn in 10 minutes. A water temperature of 125.6 degrees F could result in a first degree burn in 45 seconds and a second degree burn in 1.5 minutes. A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second-degree burn in 30 seconds. This failure of the facility was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2023.	D 113		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents	D 287	In accordance to the rule 10A NCAC 13F The table will be set with a napkin and spoon and fork. the cook will ensure that place setting will be as followed napkin, spoon and fork- plate and beverage. the supervisor will	3-15-23

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D 287	Continued From page 4 were provided a fork during their breakfast meal. The findings are: Review of Resident #2's FL-2 dated 01/31/23 revealed: -Diagnoses included dementia without behaviors, epilepsy, vitamin D deficiency, hypertension, depression and diabetes. -She was not ambulatory. Observation of the breakfast meal on 02/02/23 from 7:59am to 8:23am revealed: -There were originally 15 place settings on the table with only a spoon wrapped in a napkin. -Resident #2 was served bite size pancakes, scrambled eggs, a sausage patty, and peaches. -Resident #2 was observed attempting to eat her sausage patty with a spoon. -Resident #2's sausage fell from her mouth to the plate; she did not attempt to pick the sausage patty up with the spoon again. Interview with the cook on 02/02/23 at 8:55am revealed: -He forgot to place a fork in the place settings this morning. -He did not include a knife because he was told not to due to an incident that occurred in the facility. -He was aware the place setting for the residents should have at least a fork. Interview with the Administrator on 02/02/23 at 9:56am revealed: -He was aware the place setting for breakfast should have included a fork, knife, and a spoon. -The facility did not place knives on the table due to an incident that occurred in the past. -There should have been at least a spoon and a	D 287	Check each day to ensure Compliance to the rule area. There is a Utensil Agreement in each Chart. Resident are aware if they need a Knife then the can ask. See attached form #1. to see. (see facility File for Attachment.) WW D287 - Addendum per telephone conversation with Mr. Gedarin Roberson, Administrator on 03/21/23: If a resident is unable to ask for a knife, the facility staff will ensure food will be cut up for resident as necessary. Wendy Williams 03/21/23	

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D 287	Continued From page 5 fork in the place setting. Interview with the Owner on 02/02/23 at 3:15pm revealed: -All residents in the facility should have received at least a spoon and a fork in their place setting for breakfast. -The primary care provider (PCP) wrote a standing order for all the residents not to have a knife in their place settings due to an incident that occurred in the facility related to a knife.	D 287		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide and promote a daily activity for the residents. The findings are: Review of the facility's February 2023 activity calendar revealed: -On 02/01/23, drawing was scheduled from 10:00am to 11:00am. -On 02/02/23, cards were scheduled from	D 315	In accordance to the rule area 10A NCAC 13F .0905 (a:b) The PCA will assist with the activity to promote activities involvement by all resident. by his or her own choice to participate. [redacted] Med-Tech Supervisor is responsible for creating the activity Calendar. [redacted] will oversee the Activity Book to assure the rule area is in compliance.	3-10-23

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D 315	Continued From page 6 10:00am to 11:00am. Observation of the common living area on 02/01/23 and 02/02/23 intermittently between 10:00am- 11:00am revealed: -There were residents sitting, facing the television. -There were residents sitting on the couch facing the window; the television was not in their view. -There were no facility staff present. Interview with a medication aide/supervisor on 02/02/23 at 11:36am revealed: -A personal care aide (PCA) on duty was expected to lead the activity yesterday, 02/01/23. -She did not know why an activity was not offered today, 02/02/23. -She was assigned to assist with other duties and could not lead an activity. Interview with the Administrator on 02/02/23 at 11:28am revealed: -He expected the facility staff to lead activities with the residents. -He expected facility staff to give the residents an opportunity to have an activity. -He expected the facility staff to announce the activity and ask residents if they wanted to participate. -The PCAs were expected to lead the activity and follow the activity calendar..	D 315	D315 - Addendum per telephone conversation with Mr. Dedarin Robinson, Administrator on 03/21/23: The Activities Director (who is also the Administrator) will make random observations at the facility weekly to insure activities are being offered and completed according to the activities calendar. Wendy Williams 03/21/23	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338	In accordance to the Rule cited 10A NCAC 13F. 0909 Resident rights. An adult care home	3-15-23

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D 338	Continued From page 7 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents were maintained including residents being treated with respect and dignity as related to a resident (#1) being required to wear a hospital gown and her closet was locked with no access to her personal clothing in the closet and required to stay at the nurses' station during the day to prevent the resident from eloping; and for all residents being required to obtain toilet paper and paper towels from the nurses' station because none were stocked in the residents' bathrooms to prevent clogging of toilets. The findings are: 1. Review of Resident #1's current FL-2 dated 10/10/22 revealed: -Diagnoses included schizoaffective disorder, adjustment insomnia, and dementia. -The resident was documented as constantly disoriented with wandering behaviors. -The resident was documented as ambulatory. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 07/30/20. -The resident was documented as forgetful and needed reminders. Review of Resident #1's current assessment and care plan dated 04/08/22 revealed: -The resident was documented as having no problems with ambulation. -The resident was documented as oriented with	D 338	Staff Shall assure that the residents of all residents guaranteed under G.S 131D-21 Declaration of residents rights. are maintained and may be exercised without hinderance. [redacted] Obusiman to do training for. [redacted] waiting for date of training. Staff will assure that all residents are treated with respect and dignity as related to a resident. Resident will have a Choice in what to wear. and will have the freedom to move about in the facility. Staff will assure that resident that	3-18-23

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D 338	Continued From page 8 adequate memory. -The section for mental health history was blank. -The resident was independent with eating, ambulation, dressing, and transferring. -The resident required limited assistance by staff with toileting, bathing, and grooming. Review of Resident #1's mental health provider (MHP) visit note dated 07/20/22 revealed: -The resident was seen in the common area. -Staff reported the resident was exit-seeking at times and running toward the exit. -Staff reported they were quick to redirect the resident. Review of Resident #1's MHP visit note dated 08/30/22 revealed: -The resident was seen at the nurses' station sitting in a chair. -The resident was looking down towards the floor, had a flat affect, and no eye contact. -Every once and a while, the resident would stand up and the staff would instantly redirect her. -Staff reported the resident had extreme exiting tendencies and it had gotten worse in the last couple of weeks. -The resident would attempt to exit the facility stating her family member was at the door. Review of Resident #1's MHP visit note dated 09/20/22 revealed: -The resident was seen at nurses' station sitting in a chair. -Staff reported the resident continued exit tendencies daily and during the night. -Staff reported the resident's exit tendencies had not improved but gotten worse. -Staff had moved the resident to the nurses' station during the day to try to keep the resident from exiting the facility but the resident would say	D 338	need supervison Will have the opprotunity to go out and sit on the front proch- record will be provided for. AHS- or survey team- - Paper towels and toilet paper will be put in restrooms for resident to use- maintenance will assure that Bathroom have adequate supplies- - Resident will be able to have access to their Closets and personal items_	

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D 338	Continued From page 9 she had to go to the bathroom and tried to leave when staff was not looking. Review of Resident #1's MHP visit note dated 10/18/22 revealed: -The resident was seated at the nurses' station for close monitoring due to exiting behaviors. -Staff reported the resident did not sleep at night and was up seeking exits. -Since last visit with medication changes, staff reported the resident had no improvement with exit-seeking behaviors. Review of Resident #1's MHP visit note dated 11/14/22 revealed: -The resident was seated at the nurses' station. -The resident was alert and oriented and stated she was worried about being at the facility so long. -The resident expressed the desire to go home but no active exit-seeking during visit. -Staff reported the resident had improved with medication change last visit. -The resident still talked about needing to leave the facility but did not try to get up and leave. Review of Resident #1's MHP visit note dated 12/12/22 revealed: -The resident was seated at the nurses' station. -The resident was alert and oriented and stated she wanted to go home. -Staff reported the resident continued to desire to go home/leave the facility, with less intensity. Observation of Resident #1 on 02/01/23 at 9:03am revealed: -Resident #1 was sitting in a chair behind the nurses' station in the corner with her head in her hand looking down with no expression on her face.	D 338	D338- Addendum per telephone conversation with Mr. Gedarin Robinson, Administrator on 03/21/23: The local Ombudsman or the facility's contracted nurse will do training on residents' rights. The Administrator will make random observations at the facility at least weekly to ensure residents' rights are implemented in accordance with the rules. Wendy Williams 03/21/23	

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D 338	Continued From page 10 -The resident was wearing two hospital gowns; one gown with the opening to the front and the second gown covering the other gown with opening to the back. -The resident was wearing yellow non-skid socks and no shoes. Observation of Resident #1 on 02/01/23 at 9:39am revealed she was still sitting behind the nurses' station wearing hospital gowns and non-skid socks with her head in her hand looking down with no expression on her face. Interview with Resident #1 on 02/01/23 at 9:39am revealed: -The resident had not been in the hospital. -She was wearing hospital gowns because that was what staff put on her. -She wanted to wear her regular clothes because everyone else wore their regular clothes. -She was the only one not allowed to get dressed in their own clothes. -She did not like wearing the hospital gowns. Interview a medication aide (MA)/Supervisor on 02/01/23 at 9:39am revealed: -Staff dressed Resident #1 in hospital gowns because if she got fully dressed and put on shoes; the resident thought she was supposed to leave the facility. -The resident only wore her clothing when she was going out with her family member or going out to a medical appointment. -Resident #1 tried to run away from the facility about a year ago and went to a nearby gas station. -She could not recall the date and could not locate an incident report. -The resident would walk out the door and try to leave.	D 338		

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D 338	Continued From page 11 -The resident last tried to leave the facility a few months ago. -Staff kept Resident #1 at the nurses' station because the resident would exit the facility if they got busy and did not have time to check the door alarms when they sounded. -Staff kept Resident #1 at the nurses' station so they could see her. -She did not think about making the resident wear a hospital gown was violating the resident's rights. Observation on 02/01/23 at 9:58am revealed: -Resident #1 came out of her room with staff. -The resident was wearing a shirt and pants and non-skid socks and sat back down in the chair behind the nurses' station. -The resident was smiling. Interview with Resident #1 on 02/01/23 at 9:58am revealed the resident stated it felt good to wear her own clothes. Observation of Resident #1 on 02/01/23 at 12:52pm revealed: -Resident #1 was still sitting at the nurses' station wearing a shirt, pants, and non-skid socks. -The MA/Supervisor asked the resident if she wanted to take a walk with her. -Resident #1 walked out the front exit door to the front porch area with the MA/Supervisor. Interview with a MA on 02/01/23 at 3:50pm revealed: -Resident #1 exited the facility and went to a gas station near the facility she thought sometime in the summer of 2022. -That was the only time Resident #1 had left the facility to her knowledge. -She usually had the resident sit at the nurses'	D 338		

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D 338	Continued From page 12 station or walking beside her in the facility. -If the resident wore regular clothes, that's when the resident would try to leave the facility and say her family was coming to get her. -The resident wore the hospital gown "quite a few times a week" but staff would put regular clothing on the resident if she had to go out to a medical appointment. -If the resident got "antsy" while she was wearing regular clothing, staff would put the hospital gown back on the resident. -The resident would wear a hospital gown for a "month or so" until she calmed down. -There was a supply of hospital gowns at the facility. Observation of Resident #1 on 02/01/23 at 4:30pm revealed: -Resident #1 was sitting in the common television room with other residents. -Resident #1 was wearing a shirt, pants, and non-skid socks. Interview with Resident #1 on 02/01/23 at 4:30pm revealed: -The closet in her room with her clothing was locked and she did not have a key to the closet. -She had to ask staff to unlock her closet but staff did not always unlock it when she requested for it to be unlocked. -She had a pair of tennis shoes that she needed but staff did not let her wear shoes unless she was going to an appointment or going out with her family member. -She would like to wear shoes every day. -Staff usually made her stay at the nurses' station all day for about a year now. -Today was the first time she had been allowed to sit in the common television room in about a year. -She did not usually get asked to go outside with	D 338		

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	HAL026048	A. BUILDING: _____ B. WING _____	02/02/2023

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D 338	Continued From page 13 staff to walk like she did today. -She did not remember leaving the facility and going to a nearby gas station. Observation of Resident #1's room on 02/01/23 at 4:38pm revealed: -The door to Resident #1's closet was locked. -The door to a second closet for Resident #1's roommate was unlocked. Observation of Resident #1's room on 02/01/23 at 4:45pm revealed: -Upon request of surveyor, a personal care aide (PCA) retrieved a ring of keys from the nurses' station and used one of the keys to unlock Resident #1's closet door. -There were multiple clothing items hanging in the closet with some clothing on the floor of the closet. -There were two shoe boxes on the top shelf of the closet, with one pair of tennis shoes on top of one of the shoe boxes. -There were accessories in the closet such as belts and handbags. Interview with the PCA on 02/01/23 at 4:41pm revealed: -Resident #1's closet was locked because the resident would take all of the clothes out and change clothes every few minutes. -The resident did not have a key to the closet. -The resident's closet had always been locked to her knowledge. Interview with the Owner on 02/01/23 at 4:46pm revealed: -Resident #1 would try to leave the facility if she wore regular clothing. -Staff had a key to Resident #1's closet and could unlock it if needed at any time.	D 338		

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D 338	Continued From page 14 Interview with the Administrator on 02/02/23 at 11:02am revealed: -Resident #1 was an elopement risk. -Resident #1 left the facility "sometime last year" (did not know when) and went to a nearby gas station. -Resident #1 had not left the facility since then to his knowledge. -He saw Resident #1 wearing hospital gowns when he was at the facility. -He was not aware staff had the resident wearing hospital gowns to prevent the resident from eloping. Telephone interview with Resident #1's family member on 02/02/23 at 2:07pm revealed: -Resident #1 had a tendency to try to run away from the facility. -The resident had tried to physically run to the road on more than one occasion but she could not recall when. -She was not aware staff was having the resident to stay at the nurses' station all of the time. -She thought the resident could mingle with other residents in the common areas as long as there was supervision by staff. -She last visited the resident last month. -She always called the facility before she went as a courtesy. -When she visited last month, the resident was fully dressed with a shirt and pants. -She had seen the resident wearing a hospital gown during visits. -She thought staff had the resident to wear the hospital gowns because the resident would not leave if she had on the hospital gown and was not dressed in regular clothing. -She was concerned that the resident was wearing hospital gowns but staff explained to her	D 338		

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D 338	Continued From page 15	D 338		

that it was for the resident's safety.

Telephone interview with Resident #1's MHP on 02/02/23 at 4:24pm revealed:
-Resident #1 had exit-seeking behaviors.
-She did not recall staff reporting the resident had eloped to a nearby gas station.
-She saw Resident #1 at the facility for monthly mental health visits.
-The resident always wore two hospital gowns; one gown layered on top of the other gown.
-She did not know why the resident wore hospital gowns and no staff had ever reported any reasons for the resident wearing the hospital gowns.
-She did not ask staff why the resident wore hospital gowns all of the time because she thought it was the resident's preference.
-She asked the resident on one occasion (could not recall when) why the resident wore hospital gowns all of the time but she did not recall the resident's answer.
-She did not think she had ever seen the resident wearing any clothes other than hospital gowns.
-It was not appropriate for staff to make the resident wear hospital gowns because the resident should be allowed to wear regular clothing like all of the other residents.
-The resident was always at the nurses' station when she made her visits to the facility.
-She had not instructed staff to keep the resident at the nurses' station.
-The resident would hold her head down and the resident would not smile during her visits.
-There were door alarms on the exit doors that would alert staff when anyone entered or exited the facility.
-The resident should be able to have access to and wear her own clothing.

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D 338	Continued From page 16 2. Observation of the women's bathroom on 02/01/23 at 9:06am revealed there were no paper towels and toilet tissue. Interview with a resident on 02/02/23 at 8:26am revealed the residents in the facility had to get toilet tissue and paper towels from the nurses' station because some residents clogged the toilet. Interview with a second resident on 02/02/23 at 8:28am revealed they had to get the toilet tissue from the nurses' station to prevent them from using too much. Observation on 02/01/23 at 11:07am revealed: -There was an over-the-bed table at the nurses' station with 2 metal paper towel holders. -There was a roll of brown paper towels on one of the holders. -There were 2 rolls of white toilet paper on the other holder. -A resident walked up to the table and removed some toilet paper and some paper towels from each roll and went into the women's bathroom. Interview with the Administrator on 02/02/23 at 9:56am revealed: -There was no toilet tissue or paper towels in the bathrooms because the residents used too much toilet tissue and threw paper towels in the toilet which clogged it. -He did not know how much toilet tissue and paper towels the residents should be allowed to use. Interview with the Owner on 02/01/23 at 9:59 revealed: -There was no toilet tissue or paper towels in the bathrooms because some residents liked to put	D 338		

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D 338	Continued From page 17 them in the toilet and watch it overflow. -The only way she could reduce the plumbing bill was to remove the toilet tissue and the paper towels from the bathroom and have residents request them at the nurses' station. _____ The facility failed to ensure Resident #1 was treated with dignity and respect as related to staff making the resident wear hospital gowns and no shoes to prevent the resident from eloping. Resident #1's closet was locked and the resident did not have a key to access her own clothing in the closet because staff reported the resident would take out clothing and change clothing multiple times. Resident #1 was kept at the nurses' station by staff and not allowed to go to common areas of the facility with other residents because staff may get busy and not have time to check door alarms if the resident attempted to exit the facility. No toilet paper or paper towels were stocked in any common resident bathroom to prevent clogged toilets resulting in residents having to go to the nurses' station and get toilet paper and paper towels each time they needed to use the bathroom. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2023.	D 338		