STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 000	Initial Comments The Adult Care Licensure Section conduced an Annual survey on 10/10/24.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review of any possible changes that may be required to	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 007	Continued From page 1 the building. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capability listed on the facility's license for two residents residing at the facility who had cognitive impairments which would prevent residents from evacuating the facility independently. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 6 ambulatory residents. Observation of the census revealed there were 4 residents in the facility. Interview with the personal care aide (PCA)/live in staff on 10/10/24 at 5:15pm revealed: -Fire drills were done once a month by the Resident Care Coordinator (RCC). -The RCC set the alarm off and she (PCA) assisted the residents with getting out of the facility. -She was aware one resident had Alzheimer's. -There was one resident that had become more confused over the past 4 to 5 months and did not	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 007	Continued From page 2	C 007		

know how to evacuate.
-During the fire drills, the resident that did not know how to evacuate would just follow her out the door.

Review of Division of Health Service Regulation construction survey dated 05/15/24 revealed:
-At the time of the survey, it was observed that only one of the four residents present in the house responded and evacuated at the time the smoke detectors were activated. This was not compliant with the rule due to the home being licensed for all ambulatory clients.
-The facility should take the necessary steps to train the residents to respond and evacuate, without staff prompting or assistance, at any time the smoke detectors are activated. The residents must perform this take on their own for the home to maintain its ambulatory status.
-At the time of the survey, it was observed that per the fire drills logs drills, the residents are taking longer than 8 plus minutes. This was not compliant with the rule due to the home being licensed for all ambulatory clients.
-The facility should take the necessary steps to train the residents to respond and evacuate, without staff prompting or assistance, at any time the smoke detectors are activated. The residents must perform this task in under 8 minutes on their own for the home to maintain its ambulatory status.

Interview with the Administrator on 10/10/24 at 4:00pm revealed:
-She did not know that ambulatory residents had to be able to evacuate without prompting.
-She knew two of the residents were diagnosed with Alzheimer's.
-She knew one resident suffered from increased confusion over the past few months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 007	Continued From page 3 -She was informed by a DHSR Construction Section Surveyor in May 2024 that an evacuation time of 8 minutes or longer was not compliant with the rules. -After a DHSR Construction Section Surveyor conducted a visit in May 2024, she planned to increase the frequency of the fire drills to get the residents used to hearing the alarm so that they would know to immediately exit the building when they heard the alarm. -There was no reason given as to why the frequency of the fire drills was not increased as planned. [Refer to Tag C022 10A NCAC 13G .0302 (b) Design and Construction (Type B Violation)]	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's license and the building met the	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 4 North Carolina Building Code requirements for non-ambulatory residents for 2 of 4 residents with cognitive impairments including a resident who slept through the duration of the fire drill (#1) and a resident who was forgetful and needed reminders and did not independently respond to evacuate during a fire drill (#2). The findings are: Review of the facility's current license with an effective date of 01/01/24 revealed the facility was licensed for a capacity of 6 ambulatory residents. (The North Carolina building code defines ambulatory residents in Family Care Homes as residents able to respond and evacuate the facility without physical or verbal assistance.) Interview with the personal care aide (PCA) on 10/10/24 at 8:15am revealed: -There were 4 residents who resided in the facility. -There were 4 residents currently in the facility. Observation of the facility on 10/10/24 between 8:15am and 9:21am revealed: -The facility was not equipped with a sprinkler system. -The facility had a back door off the common area of the home that led to a ramp to the left and a set of steps straight ahead; the steps led to the back yard and the ramp led to the side of the home. -There was a side exit off the common area with a set of steps that led to the side yard. -The front entrance led to a covered porch which had a ramp to the right that led to the side and a set of steps to the front that led to the front yard. -There was about a 2-inch drop from the front door to the porch.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 5 Review of the facility's fire rehearsal reports revealed: -There was a report dated 01/15/24 at 1:00pm with the time to evacuate residents documented as 10 minutes. -There was a report dated 04/18/24 at 10:00am with the time to evacuate residents documented as 15 minutes. -There was a report dated 07/22/24 at 4:30pm with the time to evacuate residents documented as 10 minutes. -There was a report dated 07/29/24 at 5:45am with the time to evacuate residents documented as 10 minutes. -There was a report dated 9/26/24 at 11:00am with the time to evacuate residents documented as 10 minutes. -The number of residents present for each fire drill was not documented. Observation of the fire drill on 10/08/24 from 2:02pm to 2:07pm revealed: -At 1:59pm, the Surveyor instructed the Resident Care Coordinator (RCC) to initate a fire drill with instructions to not prompt or assist the residents. -The RCC set the alarm off at 2:02pm by pressing the alarm button on the control panel located on the wall in the common area by the side exit door. -The Surveyor and the RCC stood by the side exit door in the common area. -The PCA stood in the doorway of the kitchen and common area. -Resident #2 sat on the couch and continued watching television as the alarm sounded. -The PCA called Resident #2's name and started to tell her to get up. -The Surveyor stopped the PCA from telling Resident #2 what to do.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 6	C 022		

-Resident #2 asked the PCA what she should do.
-The PCA did not respond and went into the kitchen.
-Resident #2 continued to sit on the couch and watch television.
-The Surveyor went to the bedroom of Resident #1 and observed her bedroom door to be closed.
-The Surveyor opened the bedroom door and Resident #1 was in bed with her whole body, including her head, covered; she did not respond to the bedroom door opening.
-The Surveyor returned to the common area and observed Resident #2 to be gone from the couch.
-The RCC was standing in the common area and advised Resident #2 to follow the PCA out the back door.
-The alarm was turned off at 2:07pm.

1. Review of Resident #1's current FL2 dated 02/28/24 revealed:
-Diagnoses included paranoid schizophrenia, hypertension and diabetes mellitus type 2.
-There was no information provided for the resident's orientation status.
-The resident was ambulatory.

Review of Resident #1's Care Plan dated 03/09/24 revealed:
-The resident was totally dependent upon staff for bathing, dressing, and grooming.
-The resident required extensive assistance from staff with toileting, ambulation and transferring.
-The resident was ambulatory with no problems.
-The resident was oriented, forgetful and needed reminders.

Observation of Resident #1 on 10/10/24 intermittently from 8:32am and 9:21am revealed:
-She was seated at the kitchen table.
-She spoke very low, and her words were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 7	C 022		

clear at times.
-She ambulated independently throughout the home.

Observation of Resident #1 on 10/10/24 intermittently between 2:02pm and 2:07pm revealed:
-Resident #1 slept through the fire drill.
-She was in bed with the cover over her entire body, including her head.
-She never came out of her room during the fire drill.

Interview with Resident #1 at 5:49pm revealed:
-She did not hear the fire alarm.
-If she had been awake during the fire drill, she would have gotten up and walked outside.

Interview with the Resident Care Coordinator (RCC) on 10/10/24 at 2:15pm revealed:
-Resident #1 knew what to do during a fire drill.
-Resident #1 may not have heard the fire alarm because the drill was held right after lunch, and she was sleeping hard.

Refer to the second interview with the RCC on 10/10/24 at 2:15pm and 4:00pm.

Refer to the second interview with the Administrator on 10/10/24 at 2:15pm and 4:00pm.

2. Review of Resident #2's current FL2 dated 08/16/24 revealed:
-Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), anemia iron deficiency, fibromyalgia and Wolff Parkinson White Syndrome.
-There was no information provided for the resident's orientation status.
-The resident was ambulatory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 8 Review of Resident #2's Care Plan dated 10/06/23 revealed: -The resident required limited assistance for eating, bathing, dressing, and grooming. -The resident required supervision for toileting, ambulation and transferring. -The resident was ambulatory. -The resident was oriented, forgetful and needed reminders. Observation of Resident #2 on 10/10/24 intermittently between 8:32am and 12:00pm revealed: -She was seated at the kitchen table. -She ambulated throughout the home independently and slowly. -She followed the personal care aide (PCA) around the home. -The PCA assisted Resident #2 back to the common area from the kitchen by holding her under her right arm. Observation of Resident #2 on 10/10/24 between 2:02pm and 2:07pm revealed: -She sat on the couch in the common area throughout the fire drill. -The PCA attempted to tell Resident #2 what to do and Resident #2 responded by asking what was she supposed to do. -Resident #2 sat back on the couch after she was not given any guidance on what to do during the fire drill. -Resident #2 followed the PCA out of the side door near the end of the fire drill. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 9 Interview with the PCA/live in staff on 10/10/24 at 5:15pm revealed: -Resident #2 did not know what to do during a fire drill. -Resident #2 forgot a lot and just followed her out the door. -She thought Resident #2 had a dementia diagnosis. -Resident #2 had a noticeable decline over the past 4 to 5 months. -Resident #2 gradually started forgetting things, putting her clothes on inside out and putting on 2 different shoes. -She informed the Resident Care Coordinator (RCC) of Resident #2's decline when she started noticing her forgetfulness. Interview with the RCC on 10/10/24 at 2:15pm revealed Resident #2 normally followed the leader during the fire drills. Interview with the Administrator on 10/10/24 at 4:00pm revealed: -Resident #2 had become more confused in the past few months. -Resident #2 was referred to neurology due to increased confusion. Refer to the second interview with the RCC on 10/10/24 at 2:15pm and 4:00pm. Refer to the second interview with the Administrator on 10/10/24 at 2:15pm and 4:00pm. _____ Interview with the Resident Care Coordinator (RCC) on 10/10/24 at 2:15pm revealed: -She was responsible for conducting fire drills for the 1st and 2nd shift. -Fire drills were done quarterly for 1st and 2nd shift	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 10 -The Supervisor in Charge (SIC) on 3rd shift was responsible for conducting 3rd shift fire drills. -When she conducted a fire drill, she set the alarm off, and the residents evacuated. -She was prompting the residents during fire drills prior to May 2024. -A DHSR Construction Section Surveyor conducted a visit in May 2024 and informed her that she was not to prompt the resident's during the fire drills. -The 10-minute time for total evacuation documented on the fire drill rehearsal report also covered the time it took to get the residents back in the building; it was not just the amount of time it took for the residents to get out of the building. Interview with the Administrator on 10/10/24 at 2:15pm revealed: -The RCC was responsible for conducting fire drills. -She was not present when fire drills occurred. -She did not know ambulatory residents had to be able to evacuate without physical assistance or verbal prompting. -Her concern was that the residents could be injured in a fire if they could not get out on their own. -Some residents may need to be transferred to a non-ambulatory home. -A DHSR Construction Section Surveyor conducted a visit in May 2024. -After the visit from the DHSR construction section surveyor, she decided that they would do monthly drills. _____ The facility failed to ensure the building was in compliance with its current license for 6 ambulatory residents resulting in 2 of 4 residents (#1 and #2) with cognitive impairments including a resident who slept through the duration of a fire	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078107	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 5	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 022	Continued From page 11 drill (#1) and a resident who was forgetful and needed reminders who did not independently respond to evacuate during a fire drill (#2). The facility's failure was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/10/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 24, 2024.	C 022		