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THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 and the Mecklenburg County Departmnent of Social Services completed an annual survey 10/23/24 - 10/25/24.	D 000	"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State"	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 1 of 3 sampled residents (#6) was served the correct physician ordered diet. The findings are: Review of Resident #6's current FL2 dated 07/01/24 revealed: -Diagnoses included dementia with agitation. -Resident #6 was constantly disoriented. -There was no specific diet listed on the FL2. Review of the prescribed diet order for Resident #6 dated 10/04/24 revealed an order for a mechanical soft diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #6 received a mechanical soft diet. Observation of the lunch meal served on 10/23/24 beginning at 12:15pm revealed the meal consisted of turkey, sliced sweet potatoes,	D 310	Facility Executive Director will inservice the Dietary Manager and Special Care Coordinator on the rule are found to be non compliant 10A NCAC 13F .0904 (e)(4) Nutrition and food service. Facility Executive Director, Dietary Manager and Special Care Coordinator will develop and implement an internal process to manage and upkeep current resident ordered diets. Resident Care Coordinators will receive diet orders from the residents Provider and enter the order into the residents Electronic Medical Record for current reflection of orders. Resident Care Coordinator will provide a copy of the diet order to the Dietary Manager to post in the kitchen area. Resident Care Coordinator and Executive will review all current diet orders inside the electronic medical profile to ensure accuracy of current orders. Executive Director will pull a report on a weekly basis and after new diet order changes have been made to post in the kitchen for availability of review and confirmation of current diet orders accessible for staff providing meals to residents. Any found continued non compliance will result in immediate correction, inservices and reeducation of the rule area listed above and plans to correct.	Facility Expected Compliance: 12/31/24

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

Caroline Mungai | Caroline Mungai | 12/2/24

Received and Acknowledged LMJ 12/13/24

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zucchini strips and a biscuit.

Observation of Resident #6 during the lunch meal service on 10/23/24 at 12:24pm revealed Resident #6 was served a regular consistency diet that included a slice of turkey, biscuit, sliced sweet potatoes and zucchini strips.

Staff interview with Dietary Manager on 10/23/24 at 12:26pm revealed:
-Resident #6 was on a mechanical soft diet.
-The Dietary Manager removed Resident #6's regular consistency lunch plate and returned with a mechanical soft lunch plate.
-He did not know how Resident #6 got the wrong consistency lunch plate.
-Resident #6 should have been served chopped turkey and vegetables chopped or softened.

Staff interview with a personal care aide (PCA) on 10/23/24 at 12:28pm revealed:
-She removed the first lunch meal plate Resident #6 had consumed.
-Resident #6 asked for a second lunch meal plate when the PCA removed the first lunch meal plate.
-She was not aware of the diet Resident #6 was prescribed.
-She went to the kitchen and requested a second plate for Resident #6.
-She regularly worked 3rd shift and was not familiar with the diets of any of the residents.

A second interview with the Dietary Manager on 10/23/24 at 12:39pm revealed:
-Resident #6 was served a second plate of food by a PCA.
-The first plate given was a mechanical soft lunch plate, but the PCA brought Resident #6 a second plate that was a regular consistency lunch plate.
-The PCA that brought Resident #6 a second

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D 310	Continued From page 2 plate normally worked 3rd shift and did not know Resident #6's prescribed diet. -There was also only supposed to be one PCA to deliver all lunch plates to the residents in the dining room. -Resident #6 never took a bite of food from her second plate before it was removed, and she was then given a 2nd plate that was the correct therapeutic diet. Interview with the Administration on 10/23/24 at 12:45pm revealed: -Normally there was only one PCA that handed out food plates during mealtimes. -There was staff training occurring on 10/23/24 and they had staff working in the dining room who normally did not work first shift. -The PCA who brought Resident #6 a second plate of food normally worked third shift and was unfamiliar with Resident #6's prescribed diet. Interview with the Primary Care Provider (PCP) on 10/24/24 at 2:56pm revealed Resident #6 did have some difficulty swallowing at times.	D 310		
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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the rights of all residents were maintained including being treated with dignity and respect by not allowing residents into the	D 338		

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D 338	Continued From page 3 dining room for the lunch meal. The findings are: Observation of the lunch meal on 10/23/24 beginning at 12:15pm revealed: -The census for 10/23/24 was 52 residents. -There were 46 residents observed sitting in the dining room. -There was one staff member sitting while assisting a resident with the lunch meal. -There were three staff members standing in the dining room observing the residents. -There was one staff member delivering all the lunch meal plates to the residents. Observation of the lunch meal on 10/23/24 at 12:18pm revealed: -A resident was observed standing at the entrance to the dining room. -A staff member told the resident there was no room available and he would have to wait and eat. -A second resident was observed standing at the entrance to the dining room. -The staff member told them to sit in the living room and someone would come and get them when a seat was available. Interview with a resident in the living room on 10/23/24 at 12:21pm revealed: -She was waiting to eat lunch. -She was told by staff there was no room in the dining room when she went for the lunch meal. -She was told by staff to sit in the living room until there was room for her in the dining room. -She was hungry and ready to eat. Interview with a personal care aide (PCA) on 10/23/24 at 12:34pm revealed:	D 338	Facility Executive Director will inservice staff on the rule area listed above 10A NCAC 13F .0909 Resident Rights. Facility Executive Director and Dietary Manager will implement a meal schedule for staff to follow to ensure comfortability in the dining room and seating is arranged for capacity of the space. There will be a meal time list of which residents are in the first seating and which are in the second seating if all residents can not fit comfortably in the dining room at the same time. Staff will be trained on this procedure and a copy of the meal times and residents associated with each meals will be available for review and accessibility at the community Resident Care Coordinator and Dietary Manager will ensure the process is implemented and followed during meal times. Facility Executive Director will hold a training on Resident Rights by either the Clinical Nurse Consultant or local ombudsman. Any observed non compliance will result in retraining and reimplementation of the plan of correction and Resident Rights training.	Facility Expected Compliance: 12/31/24

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D 338	Continued From page 4 -There were normally two or three residents who had to wait to eat for each meal. -Usually, the staff place chairs outside the dining room in the hallway for residents to wait until space became availabe to eat. -Sometimes staff would ask the residents waiting to sit in the living room until a space became available in the dining room. -There are four residents that sit at most of the tables. -Having four residents at each table was really too much because their chairs were back-to-back and they were "too close." Interview with the Administrator on 10/25/24 at 2:53pm revealed: -There was enough room in the dining room for all residents. -They could set up for a second meal time if they needed to.	D 338		
D 612	10A NCAC 13F .1801(c) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department.	D 612		

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D 612	Continued From page 5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure their policies and procedures for infection control practices were implemented to provide protection for 52 Special Care Unit (SCU) residents related to a scabies outbreak. The findings are: Review of the facility's policies and procedures for scabies (an itchy skin rash caused by a tiny burrowing mite called sarcoples that can be spread from one person to another whom have close skin to skin contact with one another) dated September 2021 revealed: -The facility was responsible for following state specific guidelines and notifying the proper authorities as indicated. -Contact precautions should be implemented and affected residents should remain on contact precautions until 24 hours after the last treatment. -Family and friends of residents who have had close contact should be notified and given instructions regarding self-examination and treatment. -Secondary bacterial skin infections may result from untreated scabies. -Incubation period can be 2-6 weeks before onset of itching for persons with no previous exposure or 1-4 days after re-exposure. -Common locations of scabies are axillary region, under breast, around the waist, between fingers	D 612	Facility Executive Director will inservice Resident Care Coordinator on the rule area listed above to be non compliant: 10A NCAC 13F .1801(c) Infection Prevention and Control Policies and Procedures Facility Clinical Nurse Consultant will inservice staff on the following policies: Infection Control Scabies Outbreak Intervention Protocol Facility will coordinate and report symptoms to primary care provider for follow up needs and reccommendations regarding next care steps/directions to reported symptoms. During this time if the Primary Care Provider diagnosis resident with a need to implement infection control practices the facility will coordinate needs with the Health Department and other Providers to ensure recommendations and orders are followed and best practices are in place to reduce the risk of spread to residents, visitors, and staff. Facility Executive Director and Resident Care Coordinator will immediately implement the following policies to treat and manage the current scabies found in the community effecting residents. All residents and staff will be treated with ivermectin cream and will follow provider orders for treatment. Any continued reportings of symptoms will be reported to the provider for further treatment needs. If non compliance is observed Facility will reinservice and educate community staff on the proper procedures for infection control and the plan of correction listed above.	Facility Expected Compliance: 12/9/2024

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and palm of hand, inner thigh, groin, buttocks, wrist, elbows, upper backs of residents, hands of employees, or body parts that may come in contact with contaminated linens, bedding, or clothing.
-Diagnosis is established by microscopically viewing the mite or fecal pellets which are scraped from the burrow by obtaining a skin scraping.
-Staff members who may have been exposed should report any rashes developing on their bodies to the Special Care Coordinator (SCC).
-Individuals who come in contact with the infected resident or with potentially infected bedding or clothing should wear a gown or other protective clothing established by the facility.
-Apply treatment cream to the resident, change linens daily for 7 days, bathe the resident daily for 7 days, clean all areas in the resident's room, lobbies, lounges, etc., vacuum furniture, clean and disinfect the mattress, launder clothing and linens, and report any rashes to the SCC.

Review of Resident #3's current FL2 dated 09/27/24 revealed:
-Diagnoses included Alzheimer's disease and diabetes.
-Resident #3 was intermittently confused.
-Resident #3 had "normal" skin.

Review of Resident #3's physician progress note dated 05/16/24 revealed:
-A new diagnosis of scabies (a parasitic infestation of the skin) was given.
-There was visible "scabies burrows on palms and wrist."
-The physician also documented "Be aware that other staff and/or patients may be similarly afflicted."
-The physician orders on the progress note were

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for Ivermectin (a prescribed medication used to treat scabies) 3mg take 5 pills all at once, and triamcinolone acetonide (a steroid cream used to treat itching) 0.1% topical cream apply to affected areas twice a day for one week on, one week off and repeat as needed.
-A follow up appointment was needed in 6 to 8 weeks.

Review of Resident #3's May 2024 electronic medication administration record (eMAR) revealed:
-Ivermectin 3mg 5 tablets was administered on 05/17/24.
-Triamcinolone acetonide 0.1% topical cream was administered twice daily beginning 05/17/24.
-The discontinue date for the triamcinolone acetonide 0.1% topical cream was 06/14/24.

Review of Resident #3's physician progress note dated 06/13/24 revealed:
-There were no signs of "burrows" or "rashes."
-There was documentation Resident #3 was "post scabies."
-No further treatment was indicated.

Attempted interview with Resident #3 on 10/25/24 at 11:33am was unsuccessful.

Telephone interview with Resident #3's primary care provider (PCP) on 10/25/24 at 11:52am revealed:
-She did not have Resident #3 as a patient until after May 2024.
-She was unaware Resident #3 had been diagnosed with scabies in May 2024.
-Scabies were very contagious.
-If a resident was diagnosed with scabies, they should be isolated and treated until the affected skin areas were healed.

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-She had several residents that had developed a rash with itching within the past few week.
-She ordered a topical cream for these residents.
-When the topical cream was not effective, she placed an order for each of them to be seen by a dermatologist.
-She was not aware of any of the residents with rash and itching being diagnosed with scabies by the dermatologist.
-She would only treat the residents one at a time as symptoms of rash and itching developed.

Telephone interview with the facility's 2nd contracted PCP on 10/25/24 at 12:52pm revealed:
-A month ago, she was made aware by facility staff that some of her residents had developed a rash that was accompanied by itching.
-She started these residents on a medicated cream but changed it to a different medicated cream after several days with no improvement.
-She was notified by facility staff of additional residents who had developed a rash accompanied by itching and decided to treat all her residents with Ivermectin.
-She was aware the other PCP had multiple residents with rashes and itching as well.
-She did not speak with the other PCP and assumed she would treat everyone also.
-If it was a scabies outbreak, it would be highly contagious, and all residents would need to be treated.
-She was not aware a resident in the facility had a diagnosis of scabies in May 2024.

Interview with the Administrator on 10/25/24 at 2:53pm revealed:
-Facility staff had reported to the two PCP's that multiple residents had a rash with itching.
-The two PCP's treated the residents differently.

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-Her staff were not nurses or doctors and had to abide by what the direction of the PCP was for the residents.
-One of the PCP's was responsible for seeing about 30-35 of the residents.
-This PCP was conservative in treating the rash with itching and only treated one resident at a time.
-The second PCP was responsible for seeing about 10-15 of the residents.
-The second PCP was more pro-active when the rash and itching began spreading to other residents and treated all the residents at once.
-She was not aware Resident #3 had been diagnosed with scabies in May 2024.

Attempted telephone interviews with Resident #3's dermatologist on 10/25/24 at 10:53am and 12:38pm were unsuccessful.

Observation of a resident while getting a finger stick blood sugar (FSBS) checked on 10/23/24 at 11:30am revealed:
-The resident was sitting in a chair waiting to get her FSBS checked by the medication aide (MA).
-The resident was scratching her back on the chair back by moving back and forth.
-The resident told the MA her back itched.
-The MA pulled up the resident's shirt and told the resident she had a rash on her back.

Interview with the MA on 10/23/24 at 11:30am revealed:
-There were multiple residents with a rash and/or itching and were prescribed a scabicide cream (a prescribed medication to treat scabies).
-She did not know what was causing the rash or itching that was spreading amongst the residents but was told by management it was the laundry detergent.

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-There were 15 residents on the 100 hallway who were being treated with a scabicide cream.
-When a resident developed signs and symptoms of a rash and/or itching, the provider would order a cream to be applied from the neck down and leave on overnight and wash off in the morning.
-She would call to notify the provider of the resident getting her FSBS checked about the new rash and itching that developed to see if the cream needed to be ordered for that resident also.
-She did not have a rash or itching.

Observation of the medications on hand for the 100 hall on 10/23/24 at 11:30am revealed there were 15 residents being treated for a rash and itching with a scabicide cream.

Interview with a MA on 10/23/24 at 3:05pm revealed the resident getting a FSBS checked and complaining of itching and rash on her back was ordered a scabicide cream.

Interview with the Special Care Coordinator (SCC) on 10/24/24 at 10:50am revealed:
-The facility was administering a couple of different creams to some of the residents who developed rashes.
-Three residents were referred to a dermatologist and a diagnosis was not confirmed for what caused the rash.
-One dermatologist said in a progress note that the rash could be caused by an allergic reaction to soap or the laundry detergent.
-Another resident's dermatologist could not confirm if the rash was caused by scabies so the dermatologist ordered a scabicide cream as a treatment precaution.
-She did not notify anyone of the possible scabies outbreak because there were no confirmed cases

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of scabies.
-The facility changed the setting on the new washer to rinse the clothes better and changed the setting so that not as much laundry detergent was being used.

Telephone interview with a medical assistant at a resident's dermatologist office on 10/24/24 at 1:32pm revealed:
-The resident was ordered an anti-itch medication on 08/30/24 for complaints of itching.
-The resident was ordered an over-the-counter anti-itch lotion to be applied twice daily for a rash on the back, chest, arms, and legs until the rash was healed.
-The resident still complained of itching and a biopsy was completed on 09/10/24 to see what was causing the itching and rash.
-The resident was diagnosed with contact dermatitis.
-The resident was not checked for scabies because the resident had dementia, and the facility did not inform the office that there were other residents with a rash and itching.

Telephone interview with a resident's PCP on 10/24/24 at 2:55pm revealed:
-She ordered the resident getting an FSBS checked and complaining of itching and rash a scabicide cream on 10/23/24 because she did not know what caused the rash and itching.
-Several of her residents at the facility had developed rash and/or itching and were ordered a scabicide cream to treat.
-She talked to the Administrator about the rash a couple of weeks ago and the Administrator informed her that the facility checked for bed bugs and scabies.
-When the residents she provided care for developed the rash and/or itching she treated

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	HAL060125	A. BUILDING: _____ B. WING _____	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

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them with a scabicide cream and if it was ineffective she referred the residents to a dermatologist.
-At this point, all the residents in the facility were developing the rash.
-She did not perform skin scrapings to determine if the rash was caused by scabies and the skin scraping needed to be completed by the dermatologist.

Interview with a first shift MA on 10/25/24 at 10:05am revealed:
-A resident had exhibited itching with small white-head like bumps on her arms since late September 2024 and was prescribed lotion applied daily.
-Most of the residents had complained of constant itching with a rash since September 2024.
-One of the residents physicians had prescribed an anti-itch lotion to be applied daily as needed.
-She had been trained to apply sanitizer to her hands prior to contact with one resident, re-apply sanitizer before contact with a second resident, and proceed to wash her hands with soap and water prior to contact with a third resident.

Interview with a personal care aide (PCA) on 10/25/24 at 10:50am revealed:
-She provided personal care to residents who had developed a rash and itching.
-Management at the facility did not tell any of the staff what the rash and itching was caused from except it may be from an allergic reaction to the laundry detergent.
-She had developed a rash and itching between her arms and forearms and both hands about a week ago.
-She did not have the rash looked at by her physician.

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D 612	Continued From page 13 -She did not report the rash to the SCC or Administrator because she was embarrassed and did not want to tell anyone that she had it. -Her husband also developed a rash and itching and was mad at her because she "spread" something to him. Interviews with several residents on 10/25/24 between 11:45am and 12:07pm revealed: -Residents had exhibited symptoms of intense itching of their arms and torso within the past month. -A resident complained the itching had prevented her from sleeping through the night. -A resident complained of a reddish colored rash on her forearm with occasional itchiness. -A resident did not notify staff about her arms itching and was independent with bathing and dressing. -A few residents had been administered a topical cream, lotion, or medication on their skin daily for itching. -Residents continued to have itching to their skin with the medication. -Residents were permitted to sit together in the living room and dining room. -Residents were unaware why their skin felt itchy. Interview with a second PCA on 10/25/24 at 11:00am revealed: -She developed a rash and itching on her upper back and abdominal torso about 2 months ago. -Management knew there was a problem amongst residents and staff with a rash that was spreading from person to person, but no one ever told her what caused it or how it should be treated. -She thought she contracted the rash from some of the residents while providing personal care to residents.	D 612		

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D 612	Continued From page 14 -She knew of several other employees that had developed a rash and itching. -She was not informed by management to use contact precautions which included wearing gloves while providing direct contact personal care to residents who had a rash. Interview with the SCC on 10/25/24 at 11:06am revealed: -She asked first shift staff about a week or 2 weeks ago if anyone had a rash or itching and no one reported a rash. -A second shift staff member complained about bumps on her hands that itched, and the staff member used tea tree oil on the bumps, and they went away. -She was not aware of any other staff that had a rash or itching. Interview with a first-shift medication aide (MA) on 10/25/24 at 12:15pm revealed: -She knew multiple residents had a rash that caused itching. -She did not know what had caused the rash in the residents. -The SCC or Administrator did not ask her if she had developed a rash or itching. -She did not have a rash but she wore long sleeves and washed her hands. -Management did not instruct her to use gloves while applying creams or providing direct contact personal care to residents. Interview with a resident on 10/25/24 at 12:24pm revealed: -She had itching a couple of months ago but did not itch anymore. -She did not know what caused her to itch. -She did not know if any medications were applied to her skin to treat the itching.	D 612		

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D 612	Continued From page 15 Observation of a resident on 10/25/24 at 12:32pm revealed the resident was lying on her left side in bed and scratching her lower back and right side with her right hand. Telephone interview with a representative at Environmental Health Services on 10/25/24 at 9:49am revealed: -The Administrator called today (10/25/24) regarding an outbreak of a rash and/or itching and she was not able to give any guidance without knowing what was causing the rash and itching and she referred her to the Communicable Disease registered nurse (RN). -The Administrator did not previously reach out regarding the rash and itching among residents prior to 10/25/24. Telephone interview with Communicable Disease RN on 10/25/24 at 9:56am revealed: -The facility did not previously reach out for guidance regarding a rash and itching that was spreading amongst residents until 10/25/24. -She could not provide the Administrator any specific guidance without knowing a diagnosis to see if the rash and itching were infectious. -She informed the Administrator to continue administering the medications as prescribed, wash clothing and linens, and use contact precautions when providing care to residents. Interview with the Administrator on 10/24/24 at 4:40pm revealed: -There were 27 of 52 residents being treated with a scabicide cream for itching and/or rash. -None of the residents had been diagnosed with a scabies infestation. -The first resident she was aware of with a rash on the hands and complained of itching started	D 612		

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about 2 months ago.
-About 1.5 weeks ago 1 of the 2 primary care providers (PCP) expressed concerns about a spreading rash among the residents.
-She thought it was an allergic reaction to the laundry detergent and had the detergent changed.
-Some of the residents started getting "better" but the facility still had issues with other residents developing a rash and/or itching.
-She did not know of any residents or staff who had scabies.
-A PCP for 12 residents ordered a scabicide to treat all 12 of the residents and the other PCP for the remaining residents only treated the residents with a scabicide when symptoms appeared.
-She did not call the NC DHHS Public Health Division or the local health department to report the spread of a rash and/or itching among the residents.
-She did not implement any infection control measures such as placing residents with a rash and/or itching on isolation or instructed staff to use contact precautions when providing care to the residents.
-She instructed staff to clean the facility and wash their hands thoroughly after providing care.

Second interview with the Administrator on 10/25/25 at 9:03am revealed:
-She initially suspected the facility had bed bugs when two residents developed a rash and itched.
-A K-9 dog that was trained to detect bed bugs was brought into the facility and only room 211 had bed bugs.
-A contracted pest control company treated room 211 at the facility for bed bugs.
-The K-9 was brought back to the facility and no more bed bugs were found.
-She contacted the former Administrator for

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D 612	Continued From page 17 guidance because additional residents developed a rash and/or itching. -The former Administrator told her to check to see if the laundry detergent could be causing the rash and/or itching, talk to staff and make sure staff were cleaning the facility. -She retrained the PCA who also completed the laundry services on how much laundry detergent to use. -Last year, one resident developed a rash and she asked the resident's PCP to check the resident for scabies and the PCP referred the resident to a dermatologist instead. The facility failed to treat all residents after one resident had a confirmed diagnosis of scabies. The facility's failure to follow guidance related to infection prevention placed the residents at risk for increased transmission of scabies. This 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 October 24, 2024. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 9, 2024.	D 612		