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EASTON FAMILY CARE HOME	**205 A EAST SIXTH STREET BURLINGTON, NC 27215**

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C 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 06/20/24-06/24/24, with a telephone exit on 06/24/24.	C 000		
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings the Type B Violation was not abated. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#1) who was deaf and would need prompting to know to exit the facility if there was a fire when the resident was asleep. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6	C 022		

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C 022	Continued From page 1	C 022		

ambulatory residents.

Review of the facility's fire alarm procedure (not dated) revealed:
-When the fire alarm sounds, remain calm, close all the doors, and meet in the hallway.
-The person in charge needed to make sure all residents and caregivers at the time were present and accounted for.
-Call 911 and provide the following information: the location of the fire and smoke that may be visible and from what direction, and any evacuations or injuries that have occurred.
-The person in charge needs to assist and guide residents and visitors out of the facility to a safe area.
-Call the Owner/Administrator .
-When Fire and Rescue arrives direct them to the incident's location.
-Additional information included to only evacuate the people in immediate danger and keep the residents inside unless absolutely necessary to evacuate.
-Note the two main exits: front entrance and rear entrance.

Review of the facility's fire rehearsal schedule dated 06/03/24 at 2:39pm revealed:
-The alarm system was put in test mode.
-The fire alarm was activated at the pull station.
-The alarm was sounded, and all residents (5) and 2 staff exited the facility.
-Total time was 1 minute and 28 seconds.

Review of the facility's fire rehearsal schedule dated 06/17/24 at 8:16pm revealed:
-A fire drill was conducted.
-All staff and residents evacuated the facility.
-Encouraged the residents to act faster whenever the fire alarm was going off.

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C 022	Continued From page 2 -Total time was 2 minutes and 38 seconds. Review of Resident #1's current FL-2 dated 07/27/23 revealed: -Diagnoses included deaf-mute, borderline intellectual, adrenal insufficiency, hypertension, and type II diabetes. -The resident was ambulatory. -The resident's functional limitation was listed as hearing; deaf. Review of Resident #1's assessment and care plan dated 07/19/23 revealed: -The resident's hearing was very limited (deaf); there was no explanation -The resident communicated with sign language and writing. -The resident required extensive assistance from staff with toileting, bathing, dressing, and grooming/personal hygiene. -The care plan was signed by Resident #1's primary care provider (PCP) on 07/27/23. Observation of the facility on 06/20/24 at various times between 8:30am-6:00pm revealed: -There were 5 residents present in the facility. -There was one staff member in the facility. -The personal care aide (PCA) used an electric wheelchair (WC) to move about in the facility. -There was a Supervisor-in-Charge (SIC) that was in and out of the facility. -When information was requested of the SIC, she would be at the facility and then leave, leaving one staff person in the facility. -Resident #1 communicated with others through sign language and/or writing things down on paper. Interview with the PCA on 06/20/24 at 8:30am revealed:	C 022		

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C 022	Continued From page 3 -She was the only staff member working in the facility. -There was a [named] SIC who was in and out of the facility throughout the day as needed. -She used the electric WC because of knee pain. -She independently transferred in and out of the electric WC. -She came into work today, on 06/20/24. -The last time she worked at the facility was on Sunday, 06/16/24. -When she worked on 06/16/24, she was the only staff member who stayed overnight at the facility. Observation of the facility on 06/20/24 between 9:08am and 10:16am revealed: -The fire alarm was activated by the SIC. -The PCA was in the kitchen. -There was a loud audible alarm and an intermediate flashing strobe light from the alarm in the hallway. -Resident #1 was sitting in her room watching television; her door was open. -Resident #1 left her room and exited the facility with the other residents and staff. -The fire drill took 3 minutes and 30 seconds for all the residents to exit the facility. -Strobe lights were observed in Resident #1's private bedroom, hallway, and hallway bathroom. Interview with the SIC on 06/20/24 at 10:16am revealed: -She had done two recent fire drills. -She had done a fire drill on 06/17/24 at 8:00pm. -During the 8:00pm fire drill, Resident #1 was in bed with the door to her room closed. -Resident #1 appeared to be asleep; the resident's eyes were closed. -The [named] fire company installed strobe lights in Resident #1's room last week (she did not provide a date).	C 022		

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-Resident #1 was going to move to the assisted living facility, but since the fire company was able to put the strobe light in the resident's room, the resident did not have to move.

Interview with the PCA on 06/20/24 at 1:02pm revealed she thought the strobe lights in Resident #1's room would wake the resident up if there was a fire when the resident was asleep.

Observation of Resident #1 on 06/20/24 at 9:40am revealed:
-Questions were written on paper for the resident to read and respond to.
-Resident #1 answered written questions by writing her response and by body language.

Interview with Resident #1 on 06/20/24 at 9:40am revealed:
-When asked if the facility staff put anything in her room for fire alarms, she responded in writing she "went to sleep and woke up so she could see light."
-When asked if she was asleep, how would she wake up if she could not hear the fire alarm, she responded in writing that she "could not hear the fire alarm."
-When asked if she was asleep in the middle of the night, would she know if the fire alarm went off, she responded in writing, "yes, she could not remember."
-She then shook her head no, put both hands to one ear, and closed her eyes.
-When asked if the facility had a fire drill when she was asleep, she shook her head no.
-When asked if had anyone been staying in her room with her during the day or night, she responded by writing "no."
-When asked how many staff members had been working during the day, she responded in writing,

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"two staff members but just one at a time, each worked 3 days."
-When asked how many staff worked at night, she responded in writing, "one."
-When asked if she wanted things to be put in place that would keep her safe if there was a fire in the facility and she was asleep she responded in writing, "yes."

Second interview with Resident #1 on 06/20/24 at 4:37pm revealed:
-When asked if she slept well or was a light sleeper, she responded in writing that she had "sleep problems because her legs cramped, or her muscles hurt then she woke up and sometimes her head hurt bad and she had bad dreams."
-When asked if she took her nighttime medications, did it help her sleep she responded by writing "yes or no, sometimes pills are a help, but most of the time pills helped."
-When asked if she was sleeping well at 2:00am, and the fire alarm went off, would she know it was going off she responded in writing "yes or no."
-When asked if there was a fire drill in the middle of the night how would she know it, she stated in writing she "could feel it or hear it."
-When asked if she could hear any words, she responded in writing, "sometimes I can hear or cannot hear without her hearing aid."
-When asked if she wore a hearing aid, she shook her head yes and no and opened her drawer to remove a hearing aid from a box.
-When asked how often she wore her hearing aid, she demonstrated putting the hearing aid in and out of her ear several times, she then removed the hearing aid, put it back in the box, and closed the drawer.
-When asked if she could hear a loud noise like a fire alarm, she responded in writing, "yes."

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C 022	Continued From page 6 -When the surveyor covered her mouth and stated the word dog loudly, Resident #1 was asked if she heard me and she shook her head yes, when asked what the word was, she shrugged her shoulders and shook her head no. Telephone interview with the Owner/Administrator on 06/20/24 at 3:04pm revealed: -Resident #2 was "about to move to the AL facility" when someone from the local fire department told him all he needed to do was install a strobe light. -He was told the local fire department could assist but the fire personnel told him to contact the facility's fire supply company. -He did not talk to anyone about an assistive device to shake the resident's bed, because he was told a flashing light would work. -He felt confident if Resident #2 was asleep, the strobe light would wake the resident up. -He had done what needed to be done to meet the rule requirement. -There was no rule a bed shaker had to be put in place for a resident who was deaf. Telephone interview with Resident #1's court-appointed guardian on 06/21/24 at 11:22am revealed: -She did not think Resident #1 would see strobe lights if the resident was asleep. -She did not think strobe lights were an appropriate intervention; not strobe lights as the only method to alert the resident during the night. -A strobe light may work one day to wake up Resident #1 but that did not mean it would work the next time. -She thought a device to vibrate the resident's bed in addition to the strobe light would keep the resident safe in the facility. -No one had contacted her to discuss a device to	C 022		

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C 022	Continued From page 7 vibrate the resident's bed. Telephone interview with an administrative assistant from the local fire department on 06/21/24 at 11:51am revealed: -She had spoken to the facility's Owner/Administrator about the resident who was deaf. -She took the information provided by the Owner/Administrator and passed it on to two other fire personnel. -She knew one of the fire personnel suggested the resident move to a facility that was sprinkled. Telephone interview with the Assistant Fire Chief/Fire Marshal from the local fire department on 06/21/24 at 1:55pm revealed: -Resident #1 had contacted him multiple times and he talked to the resident using an interpreter. -He told Resident #1 that the best thing for the resident would be to move to the sprinkled facility because that was 99% effective in stopping or controlling a fire. -He was under the impression since the resident lived in a facility, it would be part of the facility's evacuation plan if the fire alarm activated, someone would immediately take care of the resident who was deaf. -If there was a fire in the facility, someone would need to assist Resident #1. -Strobe lights, while a resident was asleep, would not be sufficient for a resident who was deaf. -Strobe lights would only help during the day when the resident was awake. -He thought the resident was in a facility where she could be assisted. -A bed shaker properly installed was ideal and better than a strobe light alone, but the best place for the resident would be in the sprinkled facility. -He was fairly certain he left a voicemail for the	C 022		

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Owner/Administrator recommending the resident be in a sprinkled facility but did not recall when.

Telephone interview with a Fire Inspector/Investigator from the local fire department on 06/24/24 at 11:13am revealed:
-He had received a telephone call from the facility's Owner/Administrator to see what the fire department could do for a deaf resident.
-He suggested to the Owner/Administrator to call his fire alarm company to install strobe lights in every room the resident might have access to.
-He did not think strobe lights were effective if the resident was asleep, unless the resident was a light sleeper.
-Since the facility was staffed twenty-four hours a day, he thought the staff could go in and check on the resident who was deaf first to make sure the resident was up and assist if needed in getting the resident out of the facility.
-The Owner/Administrator did not ask about any assistive device that could be used when the resident was asleep.
-He did not tell the Owner/Administrator that strobe lights were the only thing required for a deaf resident.

Telephone interview with a representative from the facility's contracted fire supply company on 06/21/24 at 2:42pm revealed:
-The Americans with Disabilities Act (ADA) recommended strobe lights for people who were hard of hearing.
-Strobe lights installed at the facility were code-compliant for ADA.
-He installed a low-frequency alarm because the low frequency was better for people who were hard of hearing.
The code did not require a low-frequency alarm, just the strobe light, but he installed the

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C 022	Continued From page 9 low-frequency alarm in the resident's room. -He installed a strobe light with a "higher than was needed" candelabra and it was going to "light the resident's room up." -When asked if a deaf resident was asleep, would a strobe light wake the resident, he responded that if it did not, the strobe light was the best they had. -He had seen vibration sensors installed on beds, but he was told it was not required through the ADA. -He did not know if the facility's system could handle the bed vibrator because it used a lot of power. -He could not say if a strobe light was all that was needed to keep the resident safe, all he could say was what was required by code. -Everything he had been taught was to meet code. -Personally, he would "err on the side of caution" and would want something more, but all he had to meet was code. Telephone interview with a second representative from Resident #1's PCP's office on 06/21/24 at 4:38pm revealed because Resident #1 was deaf, the facility would need strobe lights and a person dedicated to Resident #1 to alert and get the resident to safety. Telephone interview with a representative from the facility's contracted fire supply company on 06/24/24 at 1:37pm and 3:03pm revealed: -A request was made from the facility on 06/14/24 for strobe light installation. -The installation was started and completed on the same day, on 06/17/24. Telephone interview with the Owner/Administrator on 06/24/24 at 1:12pm revealed:	C 022		

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C 022	Continued From page 10 -There were two staff members always working in the facility until the strobe light was installed in Resident #2's room. -He thought once the strobe light was installed, the facility was in compliance, and he no longer needed two staff members. -He did not contact the DHSR construction staff to discuss what was needed for compliance. ______________________ The facility failed to ensure devices for a hearing impaired resident were in place to alert a deaf resident when asleep, without staff assistance, to ensure the resident was able to independently evacuate the facility in case of an emergency such as a fire (#1). This failure was detrimental to the health, safety, and well-being of the resident and constitutes an Unabated B Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/24/24 for this violation.	C 022		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION	C 249		

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C 249	Continued From page 11 Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#3) related to leg wraps and using a sequential compression device (also known as a lymphedema pump). The findings are: Review of Resident #3's current FL-2 dated 05/30/24 revealed: -Diagnoses included cellulitis of limb, muscle weakness, hypertension, sacral pressure, and peripheral venous insufficiency. -The resident was ambulatory. Review of Resident #3's current care plan dated 05/30/24 revealed the resident required limited assistance with ambulation, grooming, bathing, and personal care. Review of Resident #3's hospital admission records dated 03/13/24-03/18/24 revealed: -Resident #3 had significant wounds to her bilateral legs with weeping: Concerned about possible infection with cellulitis. -Both lower extremities were swollen, warm, with hyperpigmentation, and with weeping. -Resident #3 was treated with intravenous (IV) antibiotics secondary to sepsis. -Resident #3 was discharged to a skilled nursing facility (SNF) for short-term rehabilitation on 03/18/24. Review of Resident #3's SNF discharge records dated 03/18/24-05/03/24 revealed: -Resident #3's cellulitis and wounds to bilateral lower legs were resolved. -Resident #3 was discharged to the facility with home health physical and occupational therapy.	C 249		

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C 249	Continued From page 12 Review of Resident #3's primary care provider (PCP) after-visit summary dated 05/08/24 revealed: -The purpose of the visit was to follow-up after hospitalization and rehabilitation following a fall. -The resident returned to the facility on 05/03/24. -Resident #3 had a history of wounds that were difficult to heal on her legs that were now healed. -Resident #3 had a diagnosis of lymphedema and had a compression device the resident used at the facility to treat this condition. -Resident #3 had chronic conditions including neuropathy of her feet and chronic peripheral edema. -Assessment and plan were to elevate legs as directed and continue using the sequential compression device. Review of Resident #3's PCP after-visit summary dated 05/15/24 revealed: -Resident #3 was seen for follow-up of chronic conditions. -Resident #3 had lymphedema, the resident had been using a sequential compression device, which helped reduce the edema. -The resident had no wounds. -Resident #3 had peripheral venous insufficiency and was measured for antiembolism stockings (calf 15, ankle 11 length 17), she was to elevate her legs as directed and continue using the sequential compression device. -Assessment and plan were to elevate legs as directed and continue using the sequential compression device. Review of Resident #3's PCP after-visit summary dated 06/12/24 revealed: -Acute condition was documented as multiple open wounds and vesicular lesions with	C 249		

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serosanguineous draining on bilateral lower legs.
-Assessment and plan were to elevate legs as directed and continue using the sequential compression device.
-Resident #3 was ordered Clindamycin 300mg three times daily.
-Resident #3 was referred to home health nursing for wound care.

Observation of Resident #3's room on 06/20/24 at 5:57pm revealed:
-There was a sequential compression device sitting on a table in the resident's room.
-The compression device consisted of a machine, tubing/wiring, and leg coverings.
-On the back of the unit there was documentation that read, the equipment was prescribed for use as follows: pressure 40mmHg, length of time 60 minutes, times per day 2.
-There was a telephone number listed for questions or further information.

Interview with Resident #3 on 06/20/24 at 11:53am revealed:
-She had not used her compression device because her legs "were open."
-She had little blisters that were draining.
-Somebody wrapped her legs.

Interview with a staff member from Resident #3's home health agency on 06/20/24 at 1:13pm revealed Resident #3 was evaluated for leg wraps on 06/13/24 which were scheduled to be changed weekly.

Telephone interview with Resident #3's home health agency's clinical nurse manager on 06/20/24 at 2:45pm revealed there was an order dated 06/12/24 for Resident #3 to continue using her sequential compression device as ordered.

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	FCL001189	A. BUILDING: ______ B. WING ______	06/24/2024

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C 249	Continued From page 14 Interview with the Supervisor-in-Charge (SIC) on 06/20/24 at 3:27pm revealed: -When Resident #3 returned from the SNF the resident was using the compression device once a day. -When she saw blisters on Resident #3's legs, she stopped using the compression device . -On Friday, 06/07/24, was when she first noticed blisters on Resident #3's legs. -The resident did not have any open wounds, but it was like the resident's legs were "weeping". -She wrapped the resident's legs with gauze. -When she returned to the facility on Monday, 06/10/24, she called Resident #3's PCP about the resident's legs. -Since Resident #3 returned from the SNF, she would "sometimes" apply moisturizer to the resident's legs, "if they were dry." -She encouraged Resident #3 to elevate her legs and limit salt intake. -Resident #3 used the compression device at least 1-2 times per week. -She would ask Resident #3 if she wanted to use the compression device and sometimes the resident would say "tomorrow." -Before Resident #3's hospitalization/SNF admission, the resident's order was to use the compression device every day. -She encouraged the resident to use it every day; the resident used it almost every day. -She had not told Resident #3's PCP the resident was using the compression device 1-2 times per week. -She talked with Resident #3's PCP about the compression device but could not recall the details. -She did not talk to Resident #3's PCP about compression stockings. -She had not ordered compression stockings for	C 249		

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C 249	Continued From page 15 Resident #3. -She had not seen Resident #3's PCP note about the compression stocking measurements dated 05/08/24. -The PCP documenting Resident #3's measurements meant the resident needed the compression stockings. -Resident #3's legs did not appear swollen when her legs were "weeping". Telephone interview with Resident #3's PCP on 06/20/24 at 5:14pm revealed: -Resident #3 did not have wounds on her lower legs when she returned to the facility from the SNF. -She wanted Resident #3 to wear some type of compression to her lower legs, and wraps were fine. -She preferred wraps for Resident #3 over the compression stockings due to Resident #3's skin being fragile and applying compression stockings could cause a skin tear. -Resident #3 should be using the compression device at least once a day. -She did not know who ordered the compression device or what the original orders were. -If Resident #3 was not using the compression device it could contribute to the resident's legs swelling so "great" that the tissues would break open, drain, and then develop wounds. -The use of compression would help prevent the skin from breaking open. -She had verbally instructed the SIC to use compression on Resident #3's legs during the day, take off at night, wash, and allow the resident's legs to air out during one of her visits; she did not recall which visit. -When she saw Resident #3 week to week the resident's legs were wrapped. -She did not know Resident #3's legs were not	C 249		

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C 249	Continued From page 16 being wrapped daily as directed. -She was shocked when she saw Resident #3's legs on 06/12/24. Second interview with the SIC on 06/20/24 at 5:24pm revealed: -She thought she wrapped Resident #3's legs "some" before the resident's legs started weeping, "not like daily". -Resident #3 came from the SNF with a bandage that "kind of stretched." -She presented an unopened roll of an elastic bandage wrap. -When asked if there were any directions on how to use the wrap, she left the room to obtain the resident's record. -When she returned, she stated, that Resident #3 had a wrap she was using to wrap the resident's legs once a week. -She would put the wrap on and take the wrap off once a week. -Resident #3 was wearing the wrap twenty-four hours a day until the SIC removed the wrap once a week to wash it and rewrap the legs. -She did the same routine every week until about the second week in June 2024. -Resident #3 returned to the facility from the SNF with the wrap on her legs, she would change it and put the wrap right back on. -Resident #3 had a wrap on all the time. -Resident #3 used her compression device 1-2 times per week. Second interview with Resident #3 on 06/20/24 at 5:59pm revealed: -Before going to the SNF, she used her compression device twice a day. -She had not used the compression device since she had returned to the facility. -The SIC wrapped her legs when she returned to	C 249		

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the facility from the SNF.
-The SIC would wash her legs, "grease" the legs up, and wrap them.
-She did not know how often the SIC wrapped her legs.

Third interview with the SIC on 06/20/24 at 6:23pm revealed:
-Resident #3's compression device was working.
-She did not recall the last time Resident #3 used the compression device .
-Resident #3 had not used the compression device since she started receiving home health nursing.
-Before Resident #3's skin was "seeping" the resident used the compression device 1-2 times weekly.

Telephone interview with Resident #3's PCP on 06/21/24 at 8:36am revealed:
-If Resident #3 was wearing leg wraps all the time, it could expose the resident to yeast, which could cause an infection.
-Resident #3's legs needed to be cleaned more often than once a week.
-Resident #3's legs needed to air out for healing, especially if the skin on the legs was not broken open.
-The SIC called her on 06/10/24 about Resident #3's legs.
-If Resident #3's legs were weeping on Friday, 06/07/24, she would have liked to have been called since the resident was such high risk.
-If Resident #3's legs were wrapped all the time, the resident's legs could not heal and could have caused the resident's current breakdown in skin integrity.

Telephone interview with a representative from Resident #3's sequential compression device

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company on 06/21/24 at 12:14pm revealed:
-A sequential compression device was used for lymphedema to help put the fluid back into the lymphatic system.
-Someone with lymphedema had lymph fluid stuck, in the case of Resident #3, in her legs, and needed a little extra help moving it back into her lymphatic system.
-The pump would be applied to Resident #3's leg, the pump inflated at the toes and worked its way up the thigh, released, and cycled again to get the fluid out of the resident's legs.
-Noncompliance could contribute to skin breakdown.
-She was not able to locate the order to determine who ordered the sequential compression device for Resident #3.
-The information documented on the back of Resident #3's sequential compression device was based on the order that was written for the user of the machine.

Telephone interview with a physician's assistant (PA) from the wound clinic on 06/21/24 at 2:01pm revealed:
-He was familiar with Resident #3 because she had been treated at the wound clinic.
-He last saw Resident #3 in January 2024, at which time, the resident's wounds had healed.
-The biggest problem Resident #3 had was noncompliance, and because of the noncompliance the resident would degrade, get better with treatment, and then she would be back at the wound clinic because of wounds.
-He could not be sure, but he felt that Resident #3's sequential compression device had been ordered by the staff at the wound clinic.
-At a minimum Resident #3 should be wearing the compression device for 60 minutes twice a day.

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C 249	Continued From page 19 -If Resident #3 was not using the lymphedema pump and had swelling in her legs, not using the pump would contribute to skin breakdown. -Resident #3 should not keep her legs wrapped at all times because it would put the resident at risk for skin breakdown. -Resident #3 should remove the wraps at least 3 times per week -There were 4 things Resident #3 should be doing to prevent skin breakdown, using the compression device, compression stockings/wraps, elevating her legs, and taking a fluid pill. Telephone interview with the Administrator on 06/20/24 at 6:06pm revealed: -He did not know how often Resident #3 used the compression device. -From what he recalled the resident did not use the compression device daily. -He did not think there was an order for Resident #3 to use the compression device daily. -He thought the compression device was old and did not have a current order because the resident had been at another facility and took the compression device with her when she left that facility. -The compression device was not set up for daily use and the resident did not use it. -If there was a recent order for Resident #3 to use the compression device, he would expect the staff to use the compression device. -If Resident #3 was refusing to use the compression device, he expected staff to document the refusal and notify the PCP. ______________________ The facility failed to ensure the implementation of physician orders for a resident (#3) with a diagnosis of lymphedema who had a history of lower leg wounds. The resident was readmitted to	C 249		

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C 249	Continued From page 20 the facility on 05/03/24 from a SNF without wounds on her lower legs. Resident #3's PCP discussed preventive measures with the SIC including wrapping the resident's legs daily, removing the wrap, washing the resident's legs, and allowing the legs to air out overnight. The resident also had an order to continue to use her sequential compression device as ordered. The resident had not used the compression device daily resulting in the resident developing wounds on her lower legs that required an antibiotic and skilled nursing care to wrap the legs. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2023.	C 249		