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ALL GOD'S CHILDREN OF BURLINGTON	101 RUBY LANE HAW RIVER, NC 27258

(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
V 000	INITIAL COMMENTS An annual and complaint survey was completed on March 12, 2019. The complaint was substantiated (intake #NC 00148402). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity	V 106		

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V 106	Continued From page 1 areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement their policy for incident reporting. The findings are: Review on 3/6/19 of a Risk Reduction and Incident Reporting policy revealed: - "It is the policy of All God's Children to provide prompt and complete responses to persons served, staff members, visitors needs in situations containing risk of injury; to call attention to physical situations that need to be investigated or resolved to ensure a safe environment for clients, staff members, and visitors; to determine issues that can be addressed for enhancement or improvement through management and planning; and to manage risk of situations with potential liability for the organization. Incidents, of a serious nature, that compromise the health and safety of persons served by All God's Children, its staff members and visitors, will be documented and reviewed for the purpose of decreasing the likelihood of similar future incidents. Incidents shall be defined to include any situation, action, or results of an action that is not consistent with the routine care of a person served, routine services provide by the organization, the routine operation of the organization, or the safety and security of	V 106		

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V 106	Continued From page 2	V 106		

environments in which serves are provided.

It is the policy of All God's Children that all situations, behaviors, and /or actions meeting the criteria for a reportable incident are documented and forwarded to the appropriate staff for further investigation and management, as per the procedures contained in this policy."

Review on 3/7/19 of a police report dated 1/26/19 revealed:
- "On the date and time above, I responded to the Burlington animal shelter in reference to [licensee] who is the staff member at all God's Children reporting that a child named [client #2] had walked away from the facility and also stated that she was going to jump off a bridge. Once I arrived to the animal shelter I located [client #2] and spoke to her about what was bothering her. I was told that she was upset because other kids have been picking on her and she told another child that she was going to jump off a bridge but explained to me that she was only joking.

I then spoke to [licensee] and she explained that [client #2] had been causing issues with the other children and that she had heard what she told another child about jumping off a bridge.

I then transported [client #2] to the magistrate's office and secured a affidavit and petition for involuntary commitment and then transported [client #2] to [local hospital] where she was then placed in their custody."

Review on 3/7/19 of a police report dated 1/28/19 with an approximate time of 7:15pm revealed:
"On the above date and time I, [police officer] responded to [facility] in reference to a juvenile problem. Upon arrival I was met by [staff #3] an

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V 106	Continued From page 3	V 106		

employee of the group home. [Staff #3] informed me that [client #1] was upstairs in her room with the door blocked. [Staff #3] went on to say [client #1] attempted to hold a pillow on her face and stick a pen her nose. Once I went up the stairs [staff #3] and I had forced the bedroom door open and I located [client #1] and two other girls in the room. [Staff #3] Informed me only [client #1] should be in the room. When I attempted to ask the girls what was going on they would not answer the question. I then told them all to sit down.

At this time [client #1] would not listen and had to be restrained and placed in the patrol car. Once [police officer] arrived on scene we determined from [client #1] actions that she would qualify for an involuntary commitment. I then transported [client #1] to [local magistrate office]. Upon arrival [police officer] stood outside with [client #1] while I swore out the papers to [magistrate]. [Magistrate] then issued the paperwork for [client #1]. [Client #1] was then transported to [hospital] and left in there custody."

Review on 3/7/19 of a police report dated 1/28/19 with an approximate time of 9:28pm revealed: "On 1/28/19 I was dispatched to All God's Children group home due to an assault on the staff by [client #3]. Upon arrival [staff #2] stated [client #3] had shoved both herself and [staff #3]. [Staff #2] also stated that when [client #3] attempted to go after [staff #4] an older employee of the group home both she and [staff #3] restrained [client #3] and put her on the floor.

[Client #3] was secured in handcuffs and I had her sit on the couch while I gathered the required information. [Staff #2] stated that perhaps [client #3] medicine wasn't right and that she was a

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V 106	Continued From page 4	V 106		

danger to others in the group home if she remained. [Staff #2] also stated that mobile crisis had already been to the group home to speak with [client #3] and she refused to participate or speak with [local agency]. IVC (Involuntary Commitment] papers were acquired from the magistrates office and [client #3] was transported to the hospital."

Review on 3/7/19 of a police report dated 1/30/19 revealed:
"On 1/30/19 at 1743 (5:43pm) I responded to a juvenile problem at [facility address]. I was advised that there were two juveniles in the residence causing issues. When I arrived I was led to the back stairwell where there were two juveniles. [Client #2] and [client #1]. They were getting up in one of the staff members, [staff #2] face to the point where [staff #2] had to push them away from her. [Client #1] then shoved [client #2] onto the stairs and acted as though [staff #2] had done it. At that point I decided to place [client #1] and [client #2] in handcuffs until I could figure out what was going on.

The staff members there said that both girls were breaking rules in the house and not doing what they were told as well as threatening staff. They were both diagnosed with multiple mental health disorders and were on medication. They said that they were unable to control them and wanted them involuntarily committed and sent to the hospital. Based on the behavior they reported and the shoving I decided to involuntarily commit them.

[Police officer] and I transported them to the magistrate's office. I spoke to the magistrate and explained what happened. He did not believe I had enough to say they were a danger to

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V 106	Continued From page 5	V 106		

themselves or others. [Police officer] and I transported them back to [facility].

Based on all the trouble we were having, the owner of the property showed up. We had a long talk with both the juveniles and the staff to try to reach some sort of understanding. The staff said that they were going to try to speak to [LME] (Local Management Entity) to see about getting one or both juveniles moved to another facility."

Review on 3/7/19 of a police report dated 2/3/19 with an approximate time of 6:05pm revealed: "On the above date and time, I [police officer] responded to [facility] in reference to juvenile problems. Upon arrival I located [client #1],] [client #2], and [client #3] in the house not complying with staff members request. As I entered the house [client #3] and [client #1] began to do as what was required of them but [client #2] continued to walk around the house and cause a Rukus. At that time I placed [client #2] in handcuffs and had her sit on the couch. I then asked the staff members what was going on and they stated the girls locked themselves in the bathroom and would not comply with what the staff was requesting them to do. All staff members agreed that [client #1] was the cause of the issues because he antagonizes the other girls.

At that time [police officer] arrived on the scene and we got the house calmed down. [Staff #4] the facility manager was then able to get [client #1's] case worker on the phone and allowed [police officer] to speak to them. [Police officer] informed the caseworker that we had been to the residence 5 times in less than a week due to [client 1's] behavior. The caseworker then informed [police officer] that due to the frequent

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V 106	Continued From page 6	V 106		

visits by law enforcement and complaint made by the group home they would be attempting to place [client #1] in another facility by 2/4/19."

Review on 3/7/19 of a police report dated 2/4/19 with an approximate time of 8:20pm revealed: "On 2/4/19 at 2020 I responded to [facility] for an assault call. The caller was a third party caller advising that staff had been assaulted at the location. While responding it was also reported that the suspects had possibly broken a window at the location.

Once I arrived I then detained three juveniles in the front yard who had been assaulting staff and throwing rocks at one of the staff members car in the parking lot. The three juveniles involved are [client #1], [client #2], and [client #3].

This incident happened shortly after we had cleared a runaway juvenile call; at the location involving all three of these juveniles."

Review on 3/7/19 of a police report dated 2/5/19 with an approximate time of 8:15pm revealed: "On the above date and time I [police officer] responded to [facility] in reference to juveniles communicating threats. Upon my arrival I observed the same three juveniles that I had dealt with the previous day sitting on a couch in the living room. I immediately separated the three juveniles due to the past incidents with them. While separating the juvenile's they became disrespectful by not following commands and attempting to talk over me."

Review on 3/6/19 of the facility's records revealed:
- No incident reports for the above incidents.

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V 293	Continued From page 7	V 293		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in	V 293		

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V 293	Continued From page 8 gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record review and interviews the facility staff failed to provide continuous supervision for 3 of 3 (#1, #2, and #3) client's to ensure safety and minimize the occurrence of behaviors related to elopement, physical aggression, and vandalism. The findings are: Review on 2/28/19 of client #1's record revealed: - Admission date of 1/14/19. - Diagnosis of Adjustment Disorder w/ Disturbance of Conduct, - Treatment Plan dated 11/20/18. Further review revealed client #1's plan did not include interventions nor strategies to address her behaviors of elopement, physical aggression, and vandalism. Review on 2/28/19 of client #2's record revealed: - Admission date of 11/21/18. - Diagnoses of Disruptive Mood Dysregulation Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Schizophrenia Spectrum - Treatment Plan dated 2/08/19. Further review	V 293		

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revealed client #2's plan did not include interventions nor strategies to address her behaviors of elopement, physical aggression, and vandalism.

Review on 2/28/19 of client #3's record revealed:
- Admission date of 7/20/18.
- Diagnoses of Oppositional Defiant Disorder
- Treatment Plan dated 2/17/19. Further review revealed client #1's plan did not include interventions nor strategies to address her behaviors of elopement, physical aggression, and vandalism.

Review on 3/6/19 of a Risk Reduction and Incident Reporting policy revealed:
- "It is the policy of All God's Children to provide prompt and complete responses to persons served, staff members, visitors needs in situations containing risk of injury; to call attention to physical situations that need to be investigated or resolved to ensure a safe environment for clients, staff members, and visitors; to determine issues that can be addressed for enhancement or improvement through management and planning; and to manage risk of situations with potential liability for the organization. Incidents, of a serious nature, that compromise the health and safety of persons served by All God's Children, its staff members and visitors, will be documented and reviewed for the purpose of decreasing the likelihood of similar future incidents.

Incidents shall be defined to include any situation, action, or results of an action that is not consistent with the routine care of a person served, routine services provide by the organization, the routine operation of the organization, or the safety and security of environments in which serves are provided.

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V 293	Continued From page 10 It is the policy of All God's Children that all situations, behaviors, and /or actions meeting the criteria for a reportable incident are documented and forwarded to the appropriate staff for further investigation and management, as per the procedures contained in this policy." Review on 3/7/19 of a police report dated 1/26/19 revealed: - "On the date and time above, I responded to the Burlington animal shelter in reference to [licensee] who is the staff member at all God's Children reporting that a child named [client #2] had walked away from the facility and also stated that she was going to jump off a bridge. Once I arrived to the animal shelter I located [client #2] and spoke to her about what was bothering her. I was told that she was upset because other kids have been picking on her and she told another child that she was going to jump off a bridge but explained to me that she was only joking. I then spoke to [licensee] and she explained that [client #2] had been causing issues with the other children and that she had heard what she told another child about jumping off a bridge. I then transported [client #2] to the magistrate's office and secured a affidavit and petition for involuntary commitment and then transported [client #2] to [local hospital] where she was then placed in their custody." Review on 3/7/19 of a police report dated 1/28/19 with an approximate time of 7:15pm revealed: "On the above date and time I, [police officer] responded to [facility] in reference to a juvenile problem. Upon arrival I was met by [staff #3] an employee of the group home. [Staff #3] informed	V 293		

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V 293	Continued From page 11	V 293		

me that [client #1] was upstairs in her room with the door blocked. [Staff #3] went on to say [client #1] attempted to hold a pillow on her face and stick a pen her nose. Once I went up the stairs [staff #3] and I had forced the bedroom door open and I located [client #1] and two other girls in the room. [Staff #3] Informed me only [client #1] should be in the room. When I attempted to ask the girls what was going on they would not answer the question. I then told them all to sit down.

At this time [client #1] would not listen and had to be restrained and placed in the patrol car. Once [police officer] arrived on scene we determined from [client #1] actions that she would qualify for an involuntary commitment. I then transported [client #1] to [local magistrate office]. Upon arrival [police officer] stood outside with [client #1] while I swore out the papers to [magistrate]. [Magistrate] then issued the paperwork for [client #1]. [Client #1] was then transported to [hospital] and left in there custody."

Review on 3/7/19 of a police report dated 1/28/19 with an approximate time of 9:28pm revealed: "On 1/28/19 I was dispatched to All God's Children group home due to an assault on the staff by [client #3]. Upon arrival [staff #2] stated [client #3] had shoved both herself and [staff #3]. [Staff #2] also stated that when [client #3] attempted to go after [staff #4] an older employee of the group home both she and [staff #3] restrained [client #3] and put her on the floor.

[Client #3] was secured in handcuffs and I had her sit on the couch while I gathered the required information. [Staff #2] stated that perhaps [client #3] medicine wasn't right and that she was a danger to others in the group home if she

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remained. [Staff #2] also stated that mobile crisis had already been to the group home to speak with [client #3] and she refused to participate or speak with [local agency]. IVC (Involuntary Commitment] papers were acquired from the magistrates office and [client #3] was transported to the hospital."

Review on 3/7/19 of a police report dated 1/30/19 revealed:
"On 1/30/19 at 1743 (5:43pm) I responded to a juvenile problem at [facility address]. I was advised that there were two juveniles in the residence causing issues. When I arrived I was led to the back stairwell where there were two juveniles. [Client #2] and [client #1]. They were getting up in one of the staff members, [staff #2] face to the point where [staff #2] had to push them away from her. [Client #1] then shoved [client #2] onto the stairs and acted as though [staff #2] had done it. At that point I decided to place [client #1] and [client #2] in handcuffs until I could figure out what was going on.

The staff members there said that both girls were breaking rules in the house and not doing what they were told as well as threatening staff. They were both diagnosed with multiple mental health disorders and were on medication. They said that they were unable to control them and wanted them involuntarily committed and sent to the hospital. Based on the behavior they reported and the shoving I decided to involuntarily commit them.

[Police officer] and I transported them to the magistrate's office. I spoke to the magistrate and explained what happened. He did not believe I had enough to say they were a danger to themselves or others. [Police officer] and I

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL GOD'S CHILDREN OF BURLINGTON	101 RUBY LANE HAW RIVER, NC 27258

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transported them back to [facility].

Based on all the trouble we were having, the owner of the property showed up. We had a long talk with both the juveniles and the staff to try to reach some sort of understanding. The staff said that they were going to try to speak to [LME] (Local Management Entity) to see about getting one or both juveniles moved to another facility."

Review on 3/7/19 of a police report dated 2/3/19 with an approximate time of 6:05pm revealed: "On the above date and time, I [police officer] responded to [facility] in reference to juvenile problems. Upon arrival I located [client #1],] [client #2], and [client #3] in the house not complying with staff members request. As I entered the house [client #3] and [client #1] began to do as what was required of them but [client #2] continued to walk around the house and cause a Rukus. At that time I placed [client #2] in handcuffs and had her sit on the couch. I then asked the staff members what was going on and they stated the girls locked themselves in the bathroom and would not comply with what the staff was requesting them to do. All staff members agreed that [client #1] was the cause of the issues because he antagonizes the other girls.

At that time [police officer] arrived on the scene and we got the house calmed down. [Staff #4] the facility manager was then able to get [client #1's] case worker on the phone and allowed [police officer] to speak to them. [Police officer] informed the caseworker that we had been to the residence 5 times in less than a week due to [client 1's] behavior. The caseworker then informed [police officer] that due to the frequent visits by law enforcement and complaint made by

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the group home they would be attempting to place [client #1] in another facility by 2/4/19."

Review on 3/7/19 of a police report dated 2/4/19 with an approximate time of 8:20pm revealed: "On 2/4/19 at 2020 I responded to [facility] for an assault call. The caller was a third party caller advising that staff had been assaulted at the location. While responding it was also reported that the suspects had possibly broken a window at the location.

Once I arrived I then detained three juveniles in the front yard who had been assaulting staff and throwing rocks at one of the staff members car in the parking lot. The three juveniles involved are [client #1], [client #2], and [client #3].

This incident happened shortly after we had cleared a runaway juvenile call; at the location involving all three of these juveniles."

Review on 3/7/19 of a police report dated 2/5/19 with an approximate time of 8:15pm revealed: "On the above date and time I [police officer] responded to [facility] in reference to juveniles communicating threats. Upon my arrival I observed the same three juveniles that I had dealt with the previous day sitting on a couch in the living room. I immediately separated the three juveniles due to the past incidents with them. While separating the juvenile's they became disrespectful by not following commands and attempting to talk over me."

Review on 3/6/19 of the facility's records revealed:
- No written documentation showing the facility developed strategies and interventions to address client #1, #2, and #3's behaviors.

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V 293	Continued From page 15 During an interview on 3/8/19 client #1 stated : - "Initially I didn't want to be at the group home. None of the staff are assisting us with coping skills. The last therapist that was helping me with coping skills was two years ago." - she admitted to being involved with the incidents involving, property destruction, walking away from the facility, assault, and verbal threats. - "I broke out the window on the staff car." - she acknowledged walking away from the approximately 4 times and the furthest distance being approximately 3 miles from the facility. - "there are 2 staff on each shift. No additional staff." -"[staff #3] threaten me with a hammer after I broke out her car window. I don't trust any of the staff at the group home. Note: The surveyor was unable to interview client #1 due to her IVC placement. Note: The surveyor was unable to interview client #3 due to her elopement from school 3/6/19. During an interview on 3/6/19 staff #2 stated: - She acknowledged the behaviors of elopement, physical aggression, and vandalism demonstrated by client #1, #2, and #3. "We called the police whenever the girls were out of control" During an interview on 3/7/19 staff #3 stated: - the clients were oppositional and defiant, often times behaviors escalating to physical aggression towards staff, elopement, and vandalism. -"[client #1, #2, and #3] broke out the car window of [staff #5]." - She acknowledged the behaviors of elopement, physical aggression, and vandalism	V 293		

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demonstrated by client #1, #2, and #3.
- She acknowledged clients being placed in the hospital for escalating behaviors and returning back to the facility without any new strategies and interventions.

During an interview on 3/7/19 staff #5 stated:
- "client #1, #2, and #3 vandalized my vehicle by breaking out one of my windows and doing damage to the body also."
"I did not threaten any of the clients with a hammer."
- She acknowledged the behaviors of elopement, physical aggression, and vandalism demonstrated by client #1, #2, and #3.

During an interview on 3/6/19 the Licensee stated:
- She acknowledged the following behaviors of: elopement, physical aggression, and vandalism demonstrated by client #1, #2, and #3.
- She acknowledged having approximately 4 incidents over the past two months where the clients repeatedly walked away from the facility. In addition, she acknowledged having approximately 4 IVC incidents without any changes to clients (#1, #2, and #3's) PCP Plans, interventions nor strategies.
- no increase of staffing to address the clients behaviors.
- "They had weekly staff meetings with the License Professional, Qualified Professional, House Manager to discuss clients behaviors".
- No documentation to support weekly meetings were occurring.
- "We usually call the police when the girls get out of control. When they return from the hospital we just process with them to make sure they are ok."
- No proactive coordination with the hospitals after a IVC discharge to discuss treatment

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V 293	Continued From page 17 strategies for the clients once they return back to the facility. -"We didn't have strategies and interventions to address client #1, #2, and #3's behaviors of elopement, assault, property destruction, and verbal threats. Review on 3/12/18 of the facility's Plan Of Protection written by the Facility Manager dated 3/11/19 revealed: "Plan of correction 1. What immediate action will the facility take to ensure the safety of the consumers? Actions for Current and Future Consumers 1. QP will complete the Risk -Assessment and Treatment Inventory for current and future consumers 2. Develop behavior plan and revise Crisis Plan for current and future consumers as needed 3. Address behavior plan and revise goals and interventions on PCP 4. Discuss next steps at the CFT meeting (Care Review, Placement, Goals etc.) 5. QP, Day Program Manager, LPC and Director will take on-call schedule and provide additional staffing as needed. Actions for Future Admissions 1. Review and Revise Intake Packet and procedures 2. Revise admission and denial criteria 3. Provide Referral Source and Guardian with Contingency Admission Letter: IF criteria of letter are not within 10 days of receipt of letter then admission will be denied. (Comprehensive Evaluation, scheduled medication management, completed intake packet, full disclosure from previous placement, therapist, psychiatrist,	V 293		

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medical doctor) educational information etc.
4. Risk Assessment, Treatment Inventory, Juvenile Substance Abuse Profile (as needed) will be completed on consumer during the first 30 days of admission. Assessment reports will be reviewed a first CFT. Goals and strategies will be revised based on the recommendations from these reports.
5. Clinical team will meet 24 hours (phone conference or in person) after each major incident. (AWOL, Fighting, Property damage, Serious threats etc.) A member of the Clinical will debrief with staff no later than 72 hours after each major incident. Emergency CFT will be scheduled no later than 10 days after a major incident.

Describe your plan to make sure that the above happens
1. QP, LPC, or Director meet weekly with staff to review Client PCP and progress.
2. QP, LPC or Director will review incident reports weekly and assess behavioral trends and adjust employee schedules and provide additional staff or floating staff based on behavioral data.
3. QP, LPC, or Director and staff will meet and review client intake and screening material prior to sending Contingency Admission Letter to assess the client's needs and if the client is suitable for admission with current population."

Client #1, #2, and #3 demonstrated behaviors of elopement, physical aggression, and vandalism between 1/26/19 through 2/5/19. Staff failed to consistently address clients behaviors and would call 911 to assist in addressing several incidents of clients behaviors. The incidents escalated to the point of police taking clients to be IVC . A total of 4 IVC placements within two months. After each IVC the clients were released back to the

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V 293	Continued From page 19 facility with no strategies and interventions to address their behaviors. In addition, the facility made no attempts to meet with the hospital to discuss aftercare plans for the clients. The facility failed to address continued elopements and physical aggression towards staff by clients after being discharged from the hospital. The facility's did not put any interventions or strategies in place to address client #1, #2, and #3's behaviors. This deficiency constitutes a Type A1 violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day	V 293		