

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on September 11, 2024. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p>	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement strategies for 3 of 3 audited clients (#1, #2 & #4). The findings are:</p> <p>Review on 9/11/24 of client #1's record revealed:</p> <ul style="list-style-type: none"> - admitted 1/3/18 - diagnoses: Schizophrenia & Dyslipidemia - no documentation of a treatment plan <p>Review on 9/11/24 of client #2's record revealed:</p> <ul style="list-style-type: none"> - admitted 3/7/14 - diagnoses: Paranoid Schizophrenia, Hypertension and Mood Disorder - no documentation of a treatment plan <p>Review on 9/11/24 of client #4's record revealed:</p> <ul style="list-style-type: none"> - admitted 9/2/20 - diagnosis: Schizoaffective disorder - a treatment plan dated 8/1/23 <p>During interview on 9/11/24 the Licensee reported:</p> <ul style="list-style-type: none"> - does not have current treatment plans at facility - will ensure treatments were up to date <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 114	Continued From page 2	V 114		
V 114	<p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure disaster drills were completed quarterly and on each shift. The findings are:</p> <p>Review on 9/11/24 of the facility's disaster drills revealed:</p> <ul style="list-style-type: none"> - no documentation of disaster drills within the last year <p>During interview on 9/11/24 the Licensee reported:</p>	V 114		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 114	<p>Continued From page 3</p> <ul style="list-style-type: none"> - staff worked 2 weeks on 2 weeks off <p>During interview on 9/11/24 client #2 reported:</p> <ul style="list-style-type: none"> - tornado drills have not been completed - he would get in the bathroom tub <p>During interview on 9/11/24 staff #1 reported:</p> <ul style="list-style-type: none"> - tornado drills were practiced with the clients in the bathroom - she was not able to locate tornado drills for the 2024 year <p>During interview on 9/11/24 the Licensee reported:</p> <ul style="list-style-type: none"> - disaster drills were completed with the clients - staff did not document the disaster drills 	V 114		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 118	<p>Continued From page 4</p> <p>(A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 3 audited clients (#4) self administered medications on the written order of a physician. The findings are:</p> <p>Review on 9/11/24 of client #4's record revealed:</p> <ul style="list-style-type: none"> - admitted 9/2/20 - diagnosis: Schizoaffective disorder - a physician's order dated 5/3/24: Fluticasone twice a day <p>Observation on 9/11/24 at 2:29pm of client #4's medications revealed:</p> <ul style="list-style-type: none"> - a Fluticasone inhaler dispensed 9/6/24 <p>Observation on 9/11/24 at 4:14pm revealed:</p> <ul style="list-style-type: none"> - client #4 enter the facility and place an inhaler on the medication cabinet - client #4 does not speak English but waved <p>During interview on 9/11/24 the Licensee reported:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 118	Continued From page 5 - client #4 had another inhaler he took to the day program - was able to administer the inhaler without the assistance of staff - will follow up with his physician for self administration order	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 289	<p>Continued From page 6</p> <p>serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to meet the scope of the program for 3 of 3 audited clients (#1, #2 & #4). The findings are:</p> <p>Review on 9/11/24 of client #1's record revealed:</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 289	<p>Continued From page 7</p> <ul style="list-style-type: none"> - admitted 1/3/18 - diagnoses: Schizophrenia & Dyslipidemia <p>Review on 9/11/24 of client #2's record revealed:</p> <ul style="list-style-type: none"> - admitted 3/7/14 - diagnoses: Paranoid Schizophrenia, Hypertension and Mood Disorder <p>Review on 9/11/24 of client #4's record revealed:</p> <ul style="list-style-type: none"> - admitted 9/2/20 - diagnosis: Schizoaffective disorder <p>During interview on 9/17/24 the Licensee reported:</p> <ul style="list-style-type: none"> - the clients have lived in the facility for years - he planned to submit a waiver to the Division of Health Service Regulation for the clients to remain in the facility <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 289		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 290	<p>Continued From page 8</p> <p>specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 3 audited clients (#1)'s treatment plan documented he was capable of being in the community without staff. The findings are:</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 290	<p>Continued From page 9</p> <p>Review on 9/11/24 of client #1's record revealed:</p> <ul style="list-style-type: none"> - admitted 1/3/18 - diagnoses: Schizophrenia & Dyslipidemia - no documentation of an unsupervised time assessment <p>Observation on 9/11/24 at 3:38pm revealed client #1 inform staff he was going on a walk</p> <p>During interview on 9/11/24 the Licensee reported:</p> <ul style="list-style-type: none"> - client #1 worked at the mall 3 times a week - he had 8 hours of unsupervised time in the community - was not able to locate the completed unsupervised time assessment 	V 290		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in an attractive and orderly manner. The findings are:</p> <p>Observation on 9/11/24 at 12:38pm of the facility revealed:</p> <ul style="list-style-type: none"> - client #3 and #4's bedroom: - bathroom ceiling vent turned side ways - white putty at the bottom of the bathroom door size of a basketball - bottom half of the bathroom mirror stained 	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-622	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/11/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AGAPE FAMILY CARE HOMES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2336 RAVENHILL DRIVE RALEIGH, NC 27615
---	--

(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 736	Continued From page 10 black During interview on 9/11/24 the Licensee reported: - would ensure the repairs were completed This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		