STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SWANGER HOME	17 HERSHEL LANE SWANNANOA, NC 28778

(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 survey was completed on 6/20/25. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. The facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (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.	V 118		

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V 118	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered on the written order of a physician and failed to keep the MAR current affecting 2 of 2 clients (#1, #2). The findings are: Review on 6/16/25 of Client #1's record revealed: -Date of admission: 12/5/22. -Diagnoses: Schizoaffective Disorder, Severe Intellectual Developmental Disability (IDD), Seizure Disorder, Hypothyroidism, Hyperlipidemia, Type 1 Diabetes with Diabetic Chronic Kidney Disease, Urinary Incontinence, Hydrocephalus. -Unsigned medical appointment summary dated 3/11/25 revealed Lantus administration instructions to inject 32 international units/milliliter (iu/ml) subcutaneously at the same time daily and increase up to 50iu daily as directed for target fasting blood glucose (BG) of 100-140. -No physician's orders present. Review on 6/17/25 of Client #1's physician's orders provided by the Director of Operations and interview with the Director of Operations revealed: -Did not have Client #1's physician's orders prior to the arrival on 6/16/25 of the Division of Health Service Regulation (DHSR) surveyor.	V 118		

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V 118	Continued From page 2 -Obtained copies of Client #1's physician's orders on 6/17/25 from the dispensing pharmacy #2. -Physician's orders included: -Levothyroxine 150 micrograms (mcg) (thyroid) - 1 tablet (tab) daily ordered 4/21/25. No prior order was available. -Loratadine 10 milligrams (mg) (allergies) - 1 tab daily ordered 4/21/25. No prior order was available. -Spironolactone 100mg (blood pressure) - 1 tab daily ordered 3/11/25. -Atorvastatin 10mg (cholesterol) - 1 tab daily ordered 3/11/25. -Omeprazole 20mg (antacid) - 1 capsule (cap) daily ordered 3/11/25. -Amlodipine 5mg (blood pressure) -1 tab daily ordered 3/11/25. -Trazodone 100mg (sleep) - 3 tabs daily ordered 2/20/25. -Clozapine 100mg (seizures) - 2 tabs daily ordered 2/20/25. -Chlorpromazine 100mg (schizophrenia) - 1 tab in the morning and 2 tabs in the evening daily ordered 8/6/24. -Levetiracetam 500mg (seizures) - 1 tab twice daily ordered 2/20/25. -Guanfacine 1mg ER (extended release) (behavior) - 2 tabs twice daily ordered 2/20/25. -Divalproex 250mg (seizures) - 1 tab twice daily ordered 2/20/25. -Lantus Solos 100 iu/ml (diabetes) - inject 15iu subcutaneously every morning, HS (hour of sleep) based on: if BG> (greater than) 220, administer 15iu; if BG 181-219, administer 12iu; if BG 150-180, administer 8iu; if BG < (less than) 150, administer 5iu; dose can be changed +/- 2iu depending on eating, illness, activity, or behaviors ordered 4/21/25. -Novolog Flexpen 100iu/ml (diabetes) - inject 5-9iu subcutaneously before meals and BG	V 118		

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V 118	Continued From page 3 correction of a maximum of 30iu daily ordered 4/21/25. No prior order was made available. Review on 6/17/25 of Client #1's undated Novolog sliding scale administration directions revealed: -Blood Sugar 200-250-sliding scale 2 units. -Blood Sugar 251-300-sliding scale 4 units. -Blood Sugar 301-350-sliding scale 6 units. -Blood Sugar 351-400-sliding scale 8 units. -Blood Sugar 401-450-sliding scale 10 units. -Blood Sugar 451-higher-sliding scale 12 units, recheck 1 hour, follow scale again. -Sliding scale did not match order dated 4/21/25. Review on 6/16/25 of Client #1's MARs for period 4/1/25-6/16/25 revealed: -April MAR -Levothyroxine was documented as administered on 4/1/25-4/20/25 without an order. (20 days) -Loratadine was documented as administered on 4/1/25-4/20/25 without an order. (20 days) -Lantus was not documented as administered on 4/1/25-4/30/25. (30 days) -Novolog was documented as administered 4 times daily on 4/1/25-4/20/25 without an order. (20 days) -May MAR -Levothyroxine was documented as administered on two separate entries on 5/1/25-5/31/25. (31 days) -Novolog was not documented as administered on 5/1/25-5/31/25. (31 days) -June MAR -The following medications were not documented as administered on 6/1/25-6/16/25 (16 days): -Levothyroxine. -Loratadine. -Spironolactone.	V 118		

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V 118	Continued From page 4 -Atorvastatin. -Omeprazole. -Amlodipine. -Trazodone. -Clozapine. -Chlorpromazine. -Levetiracetam. -Guanfacine. -Divalproex. -Novolog. -Lantus. -Neither Lantus nor Novolog were documented with the actual number of units of each medication that were administered on each MAR reviewed. Review on 6/18/25 of Client #1's BG logs for period 4/1/25-6/16/25 revealed: -Levels documented at 8am, 12pm, 4pm and 8pm daily, with the corresponding number of Novolog units administered revealed: -On 4/1/25 at 8am BG level 247; 2 units. -On 4/1/25 at 12pm BG level 360; 4 units (8 units should have been administered according to the sliding scale). -On 4/4/25 at 8am BG level 206; 2 units. -On 4/11/25 at 4pm BG level 208; 2 units. -On 4/12/25 at 8am BG level 204; 2 units. -On 4/15/25 at 12pm BG level 240; 2 units. -On 4/16/25 at 8am BG level 206; 2 units. -On 5/7/25 at 8am BG level 220; 2 units. -On 5/15/25 at 8am BG level 210; 2 units. -All other dates/times recorded revealed BG levels were between 42-196 which did not indicate a need for Novolog to be administered. Attempted interview on 6/16/25 with Client #1 was unsuccessful as Client #1 did not respond verbally to questions asked.	V 118		

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Review on 6/16/25 of Client #2's record revealed:
-Date of admission: 5/7/24.
-Diagnoses: Autistic Disorder, Severe IDD, Seizure Disorder, Blood Clots.
-No physician's orders present.

Review on 6/17/25 of Client #2's physician's orders provided by the Director of Operations and interview with the Director of Operations revealed:
-Did not have Client #2's physician's orders prior to the arrival on 6/16/25 of the DHSR surveyor.
-Obtained copies of Client #2's physician's orders on 6/17/25 from the dispensing pharmacy #2.
-Physician's orders included:
-Cetirizine 10mg (allergies) - 1 tab daily ordered 5/7/25. No prior order was available.
-Vitamin D3 25mcg (supplement) - 1 cap daily ordered 2/11/25.
-Clonazepam 0.5mg (seizures) - 1 tab daily ordered 6/5/25. No prior order was available.
-Carbamazepine 300mg ER (seizures) - 2 caps every morning and 3 caps every evening ordered 2/10/25.
-Polyethylene Glycol 3350 (constipation) - dissolve 17 grams in 4-8 ounces of water/juice daily ordered 8/20/24.
-Minocycline 50mg (acne) - 1 cap twice daily ordered 5/20/25.
-Warfarin 1mg (blood clots) - take as directed per protocol ordered 7/17/24.
-Warfarin 6mg - take as directed per protocol ordered 5/6/25. No prior order was available.
-Warfarin 10mg - 1 tab daily ordered 4/2/25.

Review on 6/16/25 of Client #2's Warfarin administration protocol provided by the Warfarin clinic revealed:
-"Goal: INR (International Normalized Ratio) 2.5-3.5"
-4/1/25: INR 4.3 - administer: Sunday 10mg,

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V 118	Continued From page 6 Monday 7mg, Tuesday 5mg, Wednesday 10mg, Thursday 7mg, Friday 10mg, Saturday 10mg, return 1 week. -4/8/25: INR 2.3 - administer: Sunday 10mg, Monday 7mg, Tuesday 10mg, Wednesday 7mg, Thursday 10mg, Friday 7mg, Saturday 10mg, return 2 weeks. -4/23/25: INR 2.5 - administer: Sunday 10mg, Monday 7mg, Tuesday 10mg, Wednesday 7mg, Thursday 10mg, Friday 7mg, Saturday 10mg, return 1 week. -4/30/25: INR 2.8 - administer: Sunday 10mg, Monday 7mg, Tuesday 10mg, Wednesday 7mg, Thursday 10mg, Friday 7mg, Saturday 10mg, return 4 weeks. -5/28/25: INR 2.7 - administer: Sunday 10mg, Monday 7mg, Tuesday 10mg, Wednesday 7mg, Thursday 10mg, Friday 7mg, Saturday 10mg, return 4 weeks. Review on 6/16/25 of Client #2's MARs for period 4/1/25-6/15/25 revealed: -April MAR -Cetirizine was documented as administered on 4/1/25-4/30/25 without an order. (30 days) -Vitamin D3 was documented as administered on 4/1/25-4/30/25 without an order. (30 days) -Clonazepam was documented as administered on 4/1/25-4/30/25 without an order. (30 days) -Polyethylene Glycol was not documented as administered from 4/1/25-4/30/25. (30 days) -Warfarin 1mg was documented as administered on 4/1/25-4/30/25 without the dosage identified. (30 days) -Warfarin 6mg was documented as administered on 4/1/25-4/30/25 without an order. (30 days) -Warfarin 10mg 1 tab daily was not	V 118		

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V 118	Continued From page 7 documented as administered on 4/3/25-4/30/25. (28 days) -May MAR -Cetirizine was documented as administered on 5/1/25-5/6/25 without an order. (6 days) -Vitamin D3 was documented as administered on 5/1/25-5/5/25 without an order. (5 days) -Clonazepam was documented as administered on 5/1/25-5/31/25 without an order. (31 days) -Minocycline was not documented as administered on 5/20/25-5/31/25. (12 days) -No documentation of Warfarin administration from 5/1/25-5/11/25. (11 days) -Warfarin 10mg 1 tab daily was not documented as administered on 5/1/25-5/11/25, 5/13/25, 5/15/25, 5/17/25, 5/19/25, 5/23/25, 5/26/25-5/31/25. (22 days) -June MAR -Clonazepam was documented as administered on 6/1/25-6/4/25 without an order. (4 days) -Carbamazepine was documented as administered on 6/1/25-6/9/25 on two separate entries. (9 days) -Minocycline was not documented as administered from 6/1/25-6/16/25. (16 days) -Warfarin 10mg 1 tab daily was not documented as administered on 6/2/25, 6/4/25, 6/6/25, 6/8/25, 6/10/25, 6/12/25, 6/14/25, 6/16/25. (8 days) Attempted interview on 6/16/25 with Client #2 was unsuccessful as Client #2 did not respond verbally to questions asked. Interview on 6/19/25 with the Pharmacist from dispensing pharmacy #1 revealed: -Packaged medications in dispill packs.	V 118		

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V 118	Continued From page 8 -Warfarin was packed in bottles due to possible changes in administration dosing on a week to week basis. "Important to follow instructions from (Warfarin) clinic." -"Coumadin (Warfarin) clinic monitors dose to adjust carefully ...therapeutic level is 2.5 ...too much Warfarin would make INR go up; not enough, INR would go down." Interview on 6/19/25 with the Pharmacist from dispensing pharmacy #2 revealed: -Received transferred physicians' orders for Client #1 and Client #2 on 6/17/25 from dispensing pharmacy #1. -" ...Without Insulin for Type 1 diabetic, well, his (Client #1's) sugar is going to be off ...could lead to serious complications, depending specifically on him and how his body uses the insulin ...pancreas is being attacked so the body is not producing insulin at all ...have to put (administer) insulin in ...what the body should be producing naturally ...should be a base level of insulin given (administered)...with Type 1 (diabetes), they will check sugar (blood glucose) before eating and may not need a dose (of insulin) if not high ...not all insulins are the same, as all diabetics are not the same ..." -He did not understand the physician's orders for Client #2's Warfarin. " ...haven't processed this particular order so I don't have the answer (explanation of orders) ...I can't speak for [dispensing pharmacy #1] ...patient (Client #2) should receive Warfarin based on INR testing and protocols ...we would reach out (to Client #2's physician) to get (Warfarin) protocols ..." -Warfarin increases INR to prevent blood clots. "The goal is to keep INR in a therapeutic range ... low INR increases the risk of blood clots ...high INR increases risk of bleeding...got to find the sweet spot in the middle ..."	V 118		

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V 118	Continued From page 9 -"This (warfarin) protocol is confusing, even to the trained person." Interviews on 6/16/25 and 6/17/25 with the Alternative Family Living (AFL) provider revealed: -Client #1 had lived in the facility for 12 years. -Client #2 moved to the facility in April 2024. -Client #1 "is two handfuls (of work to provide care for) ...spilled drink all over the table, ruined the (June 2025) MAR ...just picked up new one (MAR) on Saturday (6/14/25)." -Administered the pill packs dispensed by dispensing pharmacy #1 to Client #1. " ...don't know what units (of insulin) I gave (administered)...pharmacist just said, 'mark the MAR with initials' (after medication administration) ...sometimes I don't give any (Novolog) ...Novolog is on sliding scale ...Lantus, I give 15iu in the morning and 5-9iu at night, if needed ..." -Procedure to check Client #1's blood glucose levels was to " ...wash hands, put on gloves, wipe skin with alcohol pad, stick finger, take strip test in unit, put in sharps box ..." -Client #1 allowed her to check his blood glucose levels 4 times daily. She would then record the reading on a separate sheet from the MAR. -"Give orange juice (to Client #1) if blood sugar drops ...I can tell somethings (Client #1) is not right if he looks dizzy, staggers ...will check blood sugar again ...haven't had to recheck sugar in months." -Client #1's " ...Lantus is longer acting and Novolog is short acting ..." -"Novolog (administered) before meals on sliding scales ...5-9 units before meals ..." -"Novolog always a sliding scale ...Lantus changed in April to sliding scale ...Prior to April, Lantus was given (administered) 32 units every night ...Novolog 5-9 units based on sugar level."	V 118		

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V 118	Continued From page 10 -"Had [Client #1] for 12 years and sign (MAR) when I check his sugar ...no one ever told me differently." -Acknowledged on 6/17/25 that Client #1's June 2025 MAR had no documentation to indicate medication administration as of 6/16/25 at the start of the DHSR survey. "I completed (initialed to indicate medication administration from 6/1/25-6/16/25) June (2025) MAR yesterday (6/16/25, after the start of the DHSR survey) ...thought I was supposed to finish them (MARs) ...wanted to make things better." -Received information from Client #1's day support workers regarding his blood glucose levels when Client #1 is away from the facility during the day. "I write down what (day support) workers tell me his sugar readings are during the day." -Client #2 was prescribed Minocycline in May 2025. "I didn't know it was here ...it was in a separate thing ...I just put it in the (medication) box ...I looked at the dispill pack, but I didn't look at the bottle ..." -Administered the correct dose of Warfarin to Client #2 and identified " ...if 10mg is needed then I give him a 10mg tab ...7mg, I give one 1mg tab and one 6mg tab." Before receiving the 10mg tablets, "I was giving one 6mg tab and four 1mg tabs ..." -"Warfarin was given (administered in early May 2025); I don't know why it was not recorded (documented as administered on the MAR)." -"[Client #2] has been treated for blood clots ...has filters in arteries to keep the clots from getting to his heart ..." -Client #2 went to see his doctor twice annually, but "had blood draws (INR testing) sometimes weekly, sometimes every 4 weeks, depending on thickness of blood." -"He (Client #2) did get (was administered) the	V 118		

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Miralax (polyethylene glycol) every day in April."
-Process for medication administration was to "Open bubble packs, place one or two pills at a time in their (clients') mouths, have them drink water to make sure pills are down (swallowed) ...I document on the MAR at night ...I should document when I give (administer) it (medication)."
-Client #2's Warfarin 10mg was added on 4/2/25, but was not added to the April 2025 MAR. "Began administration on 4/4/25 based on Coumadin (warfarin) clinic results ...my sister died unexpectedly ...I just wasn't sure what I was doing ...I didn't know who to contact before ...I promise both boys (clients) got (were administered) their meds ..."
-The Qualified Professional/Registered Nurse (QP/RN) "visits every other month ...talks, checks boys' rooms, looks in fridge (refrigerator), checks fire extinguishers, makes sure chemicals are locked, sometimes looks at medications, sometimes looks at MARs ...Don't really know what she looked at because I'm busy with the boys ...meets clients in the community every other month."

Interviews on 6/18/25 and 6/20/25 with the QP/RN revealed:
-" ...Meets with [AFL provider] ...go through paperwork, including MARs, any changes, new orders ...haven't had June (2025) meeting yet. May (2025) meeting was in the community, not in the home (facility). I only take the original MAR ...absolutely would not have taken a partial April (2025) MAR ...reviewed April MAR and saw no issues."
-"[AFL provider] has had orders ...I've seen them ...had a list of meds (medications) from the doctor on a single sheet ..."
-"I did make a sheet for (AFL provider to record

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANGER HOME	17 HERSHEL LANE SWANNANOA, NC 28778

(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 12 Client #1's) blood sugars." -Conducted monthly supervision with the AFL provider and " ...would have made a note (on supervision record) but not aware of any med changes in April (2025)." -"Some of this (medication administration and documentation errors) is news to me." -"I will ensure this (medication administration and documentation) is done correctly and members (clients) are safe." -Occasionally made "drop in visits" to the facility, but "talks frequently on the phone with [AFL provider]." -"I can teach this (medication administration and documentation) and get it corrected, but she's got the piece (overall care of the clients) you can't teach ..." -"I spent 11 hours with her (AFL provider) ...I think she was just nervous with (DHSR) survey and didn't really know what to say." Interview on 6/17/25 with the Director of Operations revealed: -Unable to access previous physician's orders for Client #1 and Client #2 due to a system change in April 2025. -Changed pharmacies on 6/17/25 during the DHSR survey to keep all licensed homes receiving services from one pharmacy. -Will have the dispensing pharmacy #2 dispense medications in separate bottles rather than dispill packs to more easily manage medication administration. -Was not aware the AFL provider had not initialed to indicate medication administration on Client #1's June 2025 MAR from 6/1/25-6/16/25 when it was first reviewed by the DHSR surveyor. -"I will be monitoring the AFL (provider) now." Due to the failure to accurately document	V 118		

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V 118	Continued From page 13 medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 6/20/25 of the Plan of Protection (POP) dated 6/20/25 and signed by the QP/RN revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? A remedial medication administration class was held 06/19/2025 7:45 am-4:45 pm to ensure compliance and understanding of rules and company policy. This comprehensive instruction covered but was not limited to the following areas: client specific medication review, review of medication orders, reviewing the 6 rights of medication, reviewing the importance of Insulin and Coumadin, correct MAR documentation, and the importance of organization. [AFL provider] demonstrated proficiency in administering medication through observed practice in her home by board licensed registered nurse. This medication training encompassed patient safety through knowledge base, skill development, and learning. An in-depth conversation was had with [AFL provider] regarding the importance of asking questions if something is not understood. All prescriptions have been moved to local pharmacy [dispensing pharmacy #2]. All medication will be in bottles verses the prepackaged blister packs. A new MAR notebook was given with updated photos of clients. New Coumadin and Insulin logs were created and given. [AFL provider] was also made aware to contact QP (QP/RN) with any medication changes and verbalized understanding. There will be no new clients placed in the Swanger home (facility) until the home is in full compliance and CSB (Clear Sky Behavioral, LLC) (Licensee) is confident that she is ready.	V 118		

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V 118	Continued From page 14 -Describe your plans to make sure the above happens. [AFL provider] will be placed under intensive supervision for a period of 3 months. This will consist of unannounced weekly visits. Supervisions will review and audit for deficiencies in all areas with an emphasis being on medications. After the initial 3 months have been completed successfully, the intensity will reduce to 2 times per month and continue for an additional 3-month period. Intense supervision will be terminated upon successfully demonstrating compliance over a period of no less than 6 months." Review on 6/20/25 of the amended POP signed and dated 6/20/25 by the QP/RN, Operations of Innovations, and the Director of Operations revealed: "These supervisions will be completed by [QP/RN]." Client #1 was diagnosed with Schizoaffective Disorder, Severe IDD, Seizure Disorder, Hypothyroidism, Hyperlipidemia, Type 1 Diabetes with Diabetic Chronic Kidney Disease, Urinary Incontinence, and Hydrocephalus. Client #1's medication orders included Novolog and Lantus to assist in control of Type 1 Diabetes. Lantus was not documented as administered for either the morning or evening doses from 4/1/25 through 6/16/25 for a total of 77 days. Novolog was documented as administered 4 times daily from 4/1/25 through 4/30/25 for a total of 30 days without the specific number of units administered. There was no physician's order for Novolog prior to 4/21/25. Novolog was not documented as administered 5/1/25 through 6/16/25 for a total of 47 days. There was no documentation of administration of Levothyroxine and Loratadine	V 118		

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V 118	Continued From page 15 from 4/1/25 through 4/20/25 for a total of 20 days. There was no documentation of any medication administration for Client #1's medications from 6/1/25 through 6/16/25 for a total of 16 days. Client #2 was diagnosed with Autistic Disorder, Severe IDD, Seizure Disorder, and Blood Clots. The following medications were administered without an order: Cetirizine on 4/1/25-5/6/25 (36 days), Warfarin 6mg on 4/1/25-5/5/25 (35 days), and Clonazepam on 4/1/25-6/4/25 (65 days). Based upon the lack of information documented on the MARs, it could not be determined if Client #2 was administered the correct dose of Warfarin. He was administered Warfarin 1mg daily in April, but only for 7 days in May. He was administered Warfarin 6mg daily in April, but only for 8 days in May. The administration of Warfarin did not reflect the dosing requirements provided by Warfarin clinic. Client #2 was ordered Warfarin 10mg daily on 4/2/25 which was not documented as administered until 5/12/25 which was 40 days later. In May, Warfarin 10mg daily was documented as administered for only 9 days. He was not administered polyethylene glycol for 30 days in April. In June, polyethylene glycol was documented as administered twice for 10 days, while it was only ordered once daily. Carbamazepine was also documented as administered twice for 9 days in June. Minocycline was ordered on 5/20/25 but was not administered 5/21/25-6/16/25 (26 days). This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		