Adult Care Home Corrective Action Report (CAR)

I. Facility Name: **Wake Assisted Living**
Address: **2800 Kidd Rd. Raleigh NC 27610**
County: **Wake**
License Number: **HAL-092-144**

II. Date(s) of Visit(s): **9/2/23, 9/6/23, 9/27/23, and 10/16/23**
Purpose of Visit(s): **Complaint Investigation**
Exit/Report Date: **12/15/23**

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: **10A NCAC 13F .0909 G.S. 131D-21(4) The Declaration of Residents Rights** Rule/Statutory Reference: An adult care home shall assure that the rights of all residents a free from physical and mental abuse guaranteed under G.S. 131D-21(4) Residents Rights are maintained. Level of Non-Compliance: **Type A1 Violation** Based on observations, interviews, and record reviews the facility failed to ensure that resident 1 of 1 sampled resident (Resident # 1) were free from being physically abused by Staff A and Staff B when the resident was pinned down and punched repeatedly in her head. The findings are: Review of Resident #1's FL-2 dated 05/09/23 revealed: -Diagnoses of Dementia and was constantly disoriented. -The resident is ambulatory. -Resident resided in a special care unit. Review of Resident #1's Resident Register revealed the resident was admitted into the facility on 02/17/23: Review of anonymous phone call note dated 08/31/23 at 3:28pm revealed:	☐ POC Accepted _____ *DSS Initials*	

-Resident #1 was being abused by staff member (no name was provided).
-The resident had bruises all over her body.
-The caller had pictures.

Review of the facility's Incident/Accident report dated 09/02/23 at 5:25pm revealed:
-Resident #1 was leaning over and fell over and hit her head.
-No visual injury observed after the fall, Resident #1 developed bruising under her eyes when she was observed 30 minutes later.

Review of Resident #1's skin assessment dated 09/02/23 revealed:
-There was a yellow bruise on the resident's left cheek.
-There was a brown bruise on the left of the resident's Left back.
-There was a brown bruise on the resident's right cheek.
-There was a yellow/green bruise on the back of the resident's right arm.
-There was a scratch on the resident's right arm.
-There was a yellowish bruise/scratch on the resident's left elbow.
-There was a greenish bruise on the resident's right thigh.
-There was a greenish bruise on the resident's right shin.
-There was a yellow bruise on the resident's left thigh.
-There was a greenish yellow bruise on the back of the resident's right knee.

Review of the facility's Registered Nurse (RN) dated 09/04/23 revealed:
-On 08/31/23 the Assistant Administrator asked that she accompany her to exam Resident #1 for bruising.
-Upon the examination they noted that the resident had bruising on both her upper arms, her middle back, and right shin.
-The resident's bruises were all in different stages of healing with the bruising on her back possibly being the oldest as it had started changing to a brown/yellow color.
-The bruises on both her arms and shin were varying shades of blue and green.
-There were no reddened areas that would indicate fresh bruises.
-No other bruises were noted on her head, neck, or upper torso.
-The resident allowed them to view her lower leg but became agitated when they tried to look at her left lower leg and thighs.

-Based on observations, interviews, and record reviews at 10:19am on 09/02/23 revealed that Resident #1 was not interviewable.
-Resident was a poor historian and non-verbal.

Observation of Resident #1 by Adult Home Specialist (AHS) on 09/02/23 at 10:19am revealed:
-There was a quarter sized red bruise over her right eyebrow.
-There was a quarter sized yellow/green bruise under right eye.
-There was a nickel sized green circular bruises on her right arm.
-There was orange sized yellow/green bruise on her left shoulder.
-There was a golf ball sized yellow/green bruise on her left inner arm above elbow.

Observation of Resident #1 on 09/06/23 at 12:52pm revealed:
-There was a medium sized red bruise over her right eyebrow.
-There was a large yellow/green bruise under her right eye.
-There was a small green circular bruise on her right arm.
-There was a large yellow/green bruise on her left inner arm above her elbow.

Interview with the Administrator on 09/02/23 at 10:26am revealed:
-She was informed by the AA about the allegation of abuse when an Adult Protective Services (APS) worker came to the facility on the evening of 09/01/23.
-APS had received a report of abuse on its intake line.
-She was not aware that two staff had been named in the APS report.

Review of the facility's Investigating and Reporting Abuse, Neglect, and Exploitation policy (date unknown) revealed:
-The facility would investigate all alleged incidents of abuse.
-The facility would conduct a thorough investigation of an alleged incident.
-The Administrator or his/her designee would provide proper notification of management staff and all appropriate local and state regulatory agencies.
-The Healthcare Personal Registry or other professional licensing authority would be notified of appropriate suspected and/or substantiated incidents.

-Procedure: Any employee who witnessed an event shall notify the supervisor in charge of the allegation.
-The supervisor in charge immediately notifies the Administrator and the Resident Care Coordinator who would then begin an investigation.
-When a staff member was implicated in a potential resident abuse situation, the employee was to be removed from all patient care areas and sent home after the written narrative had been obtained.
-The employee was suspended from duty until the investigation was completed.

Review of the physician note dated 09/05/23 revealed:
-The facility contacted regarding an allegation of elder abuse involving Resident #1 and several undisclosed staff members.
-The notification was sent to the physician on 09/04/23.
-The facility staff was now doing their own skin assessment.
-Resident #1 had what appeared to be healing contusions to her face, upper arms, right skin, and her right hand.

Review of a Personal Care Aide's (PCA) written statement dated 09/05/23 revealed:
-On 08/30/23, she went to get Resident #1 out of another resident's room
-She asked where Resident #1's pants were.
-The medication aide (Staff A) said over there in the chair.
-She asked if they were going to put the resident's pants on.
-The Staff A said no and beat Resident #1 on her right side and in the head.
-They all took Resident #1 back to her room.
-Another PCA was now with the other staff assisting Resident #1.
-Staff said that the resident's wet pullup had to be taken off.
-Another PCA was standing in the middle.
-Staff B had pinned the resident down.
-Staff A also pinned the resident down on the right-hand side and started to beat the resident in the head again.
-The resident used all her strength and kicked another PCA in the stomach.
-The PCA asked the third PCA if she was okay, but PCA3 did not answer her.
-The third PCA pulled herself together from being kicked by the resident and they all decided they were finished trying to change the resident's pullup and they all walked out of the resident's room.

Interview with the PCA on 09/06/23 at 12:55pm revealed:
-She and a second PCA and Staff A were sitting at the front

desk when another staff member came to report that Resident #1 was in another resident's room with her pants off and had urinated on the floor.
-The second PCA said "I got her."
-She told the second PCA that she was going to come to assist her with the resident.
-Staff A came into the room and hit Resident #1 3 times.
-Staff A gave Resident #1 "3 blows to the head" with a closed fist.
-Staff A also choked the resident on her neck bone.
-She and the second PCA were in shock at Staff A hitting the resident.
-The resident screamed as Staff A pinned her down and choked her.
-The resident had not been combative.
-She asked Staff A if they were going to put the resident's pants on before they walked her to her room.
-Staff A said, "no we are taking her out just like this."
-Staff A walked alongside the resident on the left side.
-Staff A pulled Resident #1's left arm behind her back and would lift the resident's arm every time the resident hollered.
-On the way to the resident's room the third PCA and Staff B came to assist with the resident.
-When they got into the room the third PCA tried to remove the resident's pull up.
-Staff B started pinning the adult down with her knee.
-Staff A started hitting the Resident #1 in her head again.
-Resident #1 kicked the third PCA in the stomach.
-She went home and cried about what she had witnessed Staff A do to Resident #1.
-She had planned not to return to the facility to work.
-She had intentions of calling Law Enforcement (LE), but she never did.
-She had spoken to an agency rehabilitation therapist at the facility and was told to follow her heart and encouraged to report the incident of abuse.
-The resident did not deserve what Staff A did to her.
-Staff B did not hit the resident, however, she did pin the resident down while Staff A continued to hit the resident.

Review of Staff A's written statement dated 09/05/23 revealed:
-A staff member came and told her that Resident #1 was in another resident's room and had taken her clothes off and had urinated on the floor.

-She, the PCA, the third PCA, and Staff B had gone to the room and put the resident's pants on.
-She and the other staff bought the resident out of the room.
-She and the other staff were met by Staff B.
-They proceeded to take the resident to her room and tried to remove her pullup.
-While the staff was trying to take the resident's pullup off, the resident was kicking and biting.
-She was trying to hold the resident's hand down to take her pullup off at the same time.
-While this was happening, the resident kicked the third PCA in the stomach.
-The third PCA laughed about being kicked in the stomach and they all left out of the resident's room.

Interview with Staff A on 09/08/23 at 11:52am revealed:
-She, the PCA, and the second PCA were sitting at the nurses' station when another staff member came to report that Resident #1 was in another resident's room and had urinated on the floor.
-She went to assist the second PCA with removing the resident form the room.
-Resident #1 was being combative.
-The only staff who were in the room with the resident was her and the PCA2.
-The PCA was not in the room.
-She and PCA2 walked the resident out of the room.
-While going down the hall they met Staff B.
-When they took Resident #1 into her room, the staff present was herself, Staff B, PCA, and the third PCA.
-She held the resident's hands down.
-The resident started kicking.
-The resident kicked PCA3 in the stomach.
-The PCA was "standing there laughing."
-All the staff came out of Resident #1's room laughing.
-She did not hit Resident #1.
-She had not seen any bruises on Resident #1.

Review of Staff B's written statement dated 09/02/23 revealed:
-She was called out of her office to assist the second PCA, the third PCA, and Staff A with Resident #1.
-Staff A and the second PCA were walking Resident #1 down the hall holding her hand.
-She, Staff A, the PCA, and the third PCA had gotten Resident #1 in her room to change her.
-The resident then became combative and started kicking.

-While the resident was kicking, she fell back on her bed.
-The resident kicked one of the PCAs in the stomach.
-The other PCA just stood there while they were trying to change the resident.
-Once they were able to redirect the resident and were able to get the wet pullup off, they handed the resident her pullup and pants.
-Resident #1 proceeded to put her pants and pullup on herself.
-She, Staff A, the PCA, and the third PCA walked out of the resident's room.

Attempted telephone interview with Staff B on 09/08/23 at 11:45am was unsuccessful.

Review of the second PCA's written statement dated 09/02/23 revealed:
-On Wednesday, 08/30/23 she was asked to go and get Resident #1 because she was in another resident's room and had urinated on the floor and had taken her clothes off.
-She went walking down the hall to get the resident when Staff A said that she would assist her with the resident.
-When they got to the room, they began to try to guide the resident to take off her wet pullup.
-The resident immediately started swinging and kicking.
-The second PCA stepped back because it was normal for Resident #1 to be physically aggressive, especially when staff is trying to remove her underwear and clothes.
-The second PCA was picking up Resident's #1 wet pants.
-When she turned around Staff A had the resident by the hand, and she grabbed the resident's other hand, and they exited the room.
-She saw Staff B and the third PCA walking down the hall.
-She gave Staff B Resident #1's hand and went to assist other residents.

Review of the third PCA written statement dated 08/30/23 revealed:
-Resident #1 kicked her in the stomach real hard.
-The resident also hit her across her arm.
-She was helping the resident take her panties off because they were wet.
-Staff A did not hit Resident #1.
-Staff B did not hold the resident down.

Review of a third PCA second written statement that was given to the facility on 09/05/23 revealed:
-Resident #1 was hit in her head a lot.
-The resident was beaten badly.

-Staff B was holding Resident #1 down while the MA was beating her.

Interview with the third PCA on 09/06/23 at 1:26pm revealed:
-When she and other staff had gotten Resident #1 to her room, she tried to remove the resident's wet panties.
-The resident kicked her in the stomach.
-Staff A walked up on the resident and started hitting her in the head.
-Resident #1 "got the [expletive] beat out of her" by Staff A.
-The resident was hollering and screaming while Staff A was hitting her.
-After Staff A hit the resident in the back in the hallway, Staff A had taken the adult to her room.
-She did not know what happened after Staff A had taken the resident into her room.
-Staff B and Staff A had contacted her over the weekend, encouraging her to say that Staff A did not hit Resident #1.

Review of a second PCA's written statement dated 09/06/23 revealed:
-On 08/30/23 the day she and other staff walked down the hall, Staff A "got on top of Resident #1 and punched her in the head and the legs."
-She "stood back and watched Staff A hitting the resident because she was in shock."
-Once Staff A released the resident, she "grabbed the resident by the hand and begin to walk her up the hallway."
-Staff B and the third PCA were walking down the hall and she handed the resident off to Staff B.
-After she gave the resident to the RCC she proceeded to do a different activity.

Interview with the second PCA on 09/06/23 at 1:46pm revealed:
-When they were all in the room, the resident was on the bed and Staff A was hitting the resident "like a street fight."
-Staff A was hitting the resident in her legs, head, and had choked her.
-After the incident was over the resident was walking funny and her ponytail was off to the side.
-She had seen Staff A be a little aggressive with the residents before, but never like this.
-She was still in shock about what Staff A had done to the Resident #1.
-She did not have a problem with Staff A, "but that

[expletive] she did, I ain't with it."

Interview with Administrator on 09/06/23 at 12:31pm revealed:
-The two accused staff members (Staff A and Staff B) were suspended from work based on allegations of abuse.
-When she was notified of the abuse allegations, she told the AA to send the 2 staff home.
-She had received statements from the 2 accused staff members.
-She was still investigating the abuse allegations.

Interview with a fourth PCA on 09/06/23 at 1:20pm revealed:
-She was not at work on the day that the incident took place.
-When she returned to work, she and some other staff were sitting at the nurse's station talking about Resident #1 going into another resident's room and urinating on the floor.
-Staff A mouthed to her "yeah, I beat her ass." referring to the incident regarding the Resident #1.

Interview with the Administrator on 09/08/23 at 11:49am revealed:
-The initial 24-hour Health Care Personnel Registry report had been done on Saturday, 09/02/23.
-She did not contact LE regarding the allegations of abuse because there was no physical evidence.
-She had been notified by the AA about the allegation of abuse on Friday 09/01/2023.
-She unsubstantiated the allegations of abuse based on her internal investigation.

Interview with the AA on 09/27/23 at 11:06am revealed:
-Staff A and Staff B were still suspended from the facility.
-She never contacted LE because they had no clue that any abuse was going on until the APS worker showed up at the facility.
-On Thursday, 08/31/23 she had received an anonymous call from a man stating that he had witnessed abuse on Resident #1.
-After receiving the anonymous call, she and the nurse went to do a skin assessment on Resident #1.
-She had asked Staff B if she knew anything about what happened to Resident #1.
-Staff B mentioned the incident about Resident #1 being in

another resident's room without pants on, but there was no mention of anything physical. -She had called the Administrator to make her aware of the anonymous call alleging abuse that she received on. -On Friday, 09/01/23 the APS worker came to the facility around 5:30pm to investigate an allegation of abuse on Resident #1. -The APS worker spoke with Staff B and spoke with the Administrator over the telephone. -The AHS came to the facility on Saturday, 09/02/23 around 10:30am. -Staff B called her to let her know that the AHS was at the facility. -She came to the facility once she was notified that the AHS was there. -The facility's policy on allegations of abuse was for management to do an internal investigation, get witness statements, depending on the finding remove the accused staff from the facility. Interview with the Administrator on 10/02/2023 at 1:45pm revealed: -On Friday, 09/01/23 she was notified that APS had come to investigate an allegation of abuse of Resident #1. -She instructed the AA to get statements from any staff who were involved. -There were not any staff named by the APS worker on 09/01/23. -On Saturday, 09/02/23 the AHS came to initiate a compliant investigation of abuse related to Resident #1. -Staff A and Staff B were suspended. -She told the AA to speak to staff and get witness statements on 09/02/2023. -On 09/02/23 she instructed the AA to do a full body assessment on Resident #1. -On Monday, 09/04/23 she read the staff statements and followed up with the staff. -The PCA's statement was the same at was she was saying in her interview. -The third PCA did not want to write another a second statement because she had already written one. -The PCA wrote the third PCA's second witness statement for her and the third PCA signed it. -She did not notice any red or purple bruises on Resident #1. -She did notice a sore on Resident #1's arm.		

-For allegations of abuse, the facility's policy was to remove the alleged staff, assess the resident, send to the emergency room if necessary and follow up with the resident's doctor. -Staff now knows how to contact her to report any abuse. -She could not definitively say that abuse happened in this case, but she believed it was in the best interest for the two accused staff (Staff A and Staff B) not to return to work at the facility.		
The facility failed to ensure Resident #1 was free from physical abuse of the resident by Staff A and Staff B resulting in bruises on the resident's face, back and arms. This resulted in severe physical harm to the resident and constitutes a Type A1 Violation.		
Rule/Statute Number: **10A NCAC 13F .1212(d) Reporting of Accidents and Incidents**		
Rule/Statutory Reference: (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect, or exploitation of a resident.		
Level of Non-Compliance: **Type B Violation**		
Based on observations, interviews, and record reviews, the facility failed to assure that residents were free from abuse to two staff (Staff A and Staff B to Resident (#1) physical abuse. The findings are: Review of Resident #1's FL-2 dated 05/09/23 revealed: -Diagnoses of Dementia and was constantly disoriented. Review of Resident #1's Resident Register revealed the resident was admitted into the facility on 02/17/2023: Attempted interview with Resident #1 at 10:19am on 09/02/2023 revealed: -Resident was a poor historian and non-verbal. -Photos taken of the resident's torso, face, back, and arms. Observation of Resident #1 by Adult Home Specialist (AHS) on 09/02/23 at 10:19am revealed: -There was a quarter sized red bruise over her right eyebrow. -There was a quarter sized yellow/green bruise under right eye.		

-There was a nickel sized green circular bruises on her right arm.
-There was orange sized yellow/green bruise on her left shoulder.
-There was a golf ball sized yellow/green bruise on her left inner arm above elbow.

Observation of Resident #1 on 09/06/23 at 12:52pm revealed:
-There was a medium sized red bruise over her right eyebrow.
-There was a large yellow/green bruise under her right eye.
-There was a small green circular bruise on her right arm.
-There was a large yellow/green bruise on her left inner arm above her elbow.

Attempted telephone interview with Staff B on 09/08/23 at 11:45am was unsuccessful.

Interview with Administrator at 11:49am on 09/08/23 revealed:
-The initial 24-hour report had been done on Saturday, 09/02/23.
-She did not contact Law Enforcement (LE) regarding the allegations of abuse because there was no physical evidence.
-She had been notified by the Assistant Administrator (AA) about the allegation of abuse on Friday 09/01/23.
-She unsubstantiated the allegations of abuse based on her internal investigation.

Interview with Staff A on 09/08/23 at 11:52am revealed:
-She and other staff were sitting at the nurses' station when another staff member came to report that Resident #1was in another resident's room and had urinated on the floor.
-She went to assist PCA2 with removing the resident form the room.
-Resident #1 was being combative.
-The only staff who were in the room with the resident was her and the PCA2.
-PCA was not in the room.
-She and PCA2 walked the resident out of the room.
-While going down the hall they met Staff B.
-When they took Resident #1 into her room, the staff there was present was herself, Staff B, PCA, and PCA3.
-She had held the resident's hands down.
-The resident started kicking.
-The resident kicked PCA3 in the stomach.

-PCA was “standing there laughing.”
-All the staff came out of Resident #1’s room laughing.
-She did not hit Resident #1.
-She had not seen any bruises on Resident #1.

Interview with AA at 11:06am on 9/27/23 revealed:
-Staff A and Staff B were still suspended from the facility.
-They are waiting for the APS and County Complaint Investigations to be closed.
-She never contacted LE because they had no clue that any abuse was going on until the APS worker showed up at the facility.
-Since the alleged incident she had been watching the facility cameras more.
-She and the Administrator had done an in-service on resident rights with all staff.
-She and the Administrator spoke with staff about the importance of abuse to upper management.
-She and the Administrator let staff know that there would be no repercussions for making reports of abuse.
-If there are any allegations of abuse, management will investigation the matter.
-She and the Administrator also spoke with staff about redirecting residents.
-The facility’s policy on allegations of abuse is for management to do an internal investigation, get witness statements, depending on the finding remove the accused staff from the facility.

Interview with agency rehab therapist at 12:00pm on 09/27/23 revealed:
-PCA asked her how she should go about reporting an incident of abuse.
-She told the PCA that she needed to report the incident to her boss withing 24-hours.
-She told the PCA that her boss should then five her directions on what she should do.
-The PCA told her that the abuse was “really bad.”
-She had suggested that PCA report the incident to Staff B.
-The PCA said that she did not feel comfortable making the report to Staff B or AA.
-On the day of the incident she recalled two staff members aggressively dragging Resident #1 down the hall.
-Resident #1 was of course fighting the staff because she was being dragged.

-She saw the PCA, the third PCA, Staff A, and Staff B with Resident #1. -They all had taken Resident #1 into her room and closed the door. -Abuse happened at the facility a lot. -Residents have a lot of unexplained bruises. -Staff A did a lot of screaming and yelling at the residents. -Since Staff A and Staff B have been suspended, things have been a lot calmer at the facility. -There had not been as much yelling since Staff A and Staff B had been suspended. -The therapist room is next door to Resident #1's room. -She heard a lot of screaming and bumping from Resident #1's room when all the staff was in the room with the resident. -It sounded as if furniture was being moved around. -PCA said that she thought that the police needed to be involved. -She informed PCA that she could contact the State to report the abuse. -On 08/31/23 around 3:30pm or 4:00pm Staff B came down the hall yelling for the staff to go to her office now. -The nurse and the AA came down the hall with Resident #1. -The nurse and the AA pulled up Resident #1's shirt and was looking at her back. -She did not know the outcome of the skin assessment done by the nurse and the AA. Interview with the Administrator at 1:45pm on 10/02/23 revealed: -On Friday, 09/01/23 she was notified that APS had come to investigate an allegation of abuse of Resident #1. -She instructed the AA to get statements from any staff who were involved. -There were not any staff named by the APS worker on 09/01/23. -On Saturday, 09/02/23 the AHS came to initiate a compliant investigation of abuse related to Resident #1. -The two accused staff named in the abuse complaint were suspended. -She told the AA to speak to staff and get witness statements on 09/02/23. -On 09/02/23 she instructed the AA to do a full body assessment on Resident #1.		

-On Monday, 09/04/23 she read the staff statements and follow up with the staff. -The PCA statement was the same at was she was saying in her interview. -The third PCA did not want to write another a second statement because she had already written one. -PCA wrote the third PCA's second witness statement for her and the third PCA signed it. -She did not notice any red or purple bruises on the resident. -She did notice a sore on Resident #1's arm. -For allegations of abuse the facility's policy is to remove the alleged staff, assess the resident, send to the emergency room if necessary and follow up with the resident's doctor. -The only thing that she had failed to do was to advise the AA to contact LE. -Contacting law enforcement was the only part in the policy that she did not get done. -She had meetings with staff emphasizing the importance of residents being free from abuse. -Staff now knows how to contact her to report any abuse. -Staff was made aware that there is always someone who they can confide in to report any cases of abuse. -She could not say definitively that abuse happened in this case, but she believed it was in the best interest for the two accused staff not to return to work at the facility. **CORRECTION DATE FOR THIS A1 VIOLATION SHALL NOT EXCEED 2/23/24.**		

IV.Delivered Via:	**Email**	Date: 12/15/23
DSS Signature:	*Kellie Armstrong*	Return to DSS By: **1/12/24**

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		

☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			