# Adult Care Home Corrective Action Report (CAR)

**I.** Facility Name: Brighton Gardens of Raleigh
Address: 3101 Duraleigh Rd, Raleigh, NC 27612
County: Wake
License Number: HAL-092-024

**II.** Date(s) of Visit(s): 6/29/23, 7/19/23, 8/30/23, 9/14/23, 10/10/23
Purpose of Visit(s): Elopement Investigation
Exit/Report Date: 10/30/23

**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**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Rule/Statutory Reference (text of the rule/statute cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent**:<br>*(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 .0901(b)**<br>Rule/Statutory Reference: **Personal Care & Supervision**- Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br>Level of Non-Compliance: Type A1 Violation<br><br>Findings:<br><br>Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 7 sampled residents (Residents #1) residing in Assisted Living (AL) who had dementia, confusion and wandering behaviors who exited the facility across a busy city street with his walker, fell, and laid unable to get up off the side of that road until a city bus drove passed him.<br><br>The Findings are:<br><br>Review of the facility's policy on resident elopement and missing residents revealed dated 5/2023.<br>-Elopement is an act or instance of leaving a safe area or safe premises.<br>-The Executive Director (ED)/Department Coordinators are responsible for overseeing the facility's Safe Leaving Program and resident search coordination.<br>-Team members are to immediately respond to alarms, | ☐ POC Accepted _____<br>*DSS Initials* | |

reason for alarm, doors and the area surrounding the alarmed exit door.
-If a resident cannot be located, staff is to notify the ED and first responders for direction on the search plan.
-The ED/designee is to notify Law Enforcement and regulatory agencies within the time frames required by law, no greater than 30-minute lapse between the missing resident search and Law Enforcement notification.
-The resident's description and any memory loss condition and the resident's former home and favorite place information are to be given to Law Enforcement.
-ED/designee shall contact family/responsible party no more than 30 minutes from start of the search for possible destinations and contact Safe Return Program of the Alzheimer's Association, if resident registered.
-Upon resident return, a physical exam is to be completed by a Licensed Practical Nurse (LPN); the LPN was to arrange follow-up medical evaluation; care plans were to be updated; the Resident Care Coordinator (RCC) was to coordinate new provider's orders and progress notes on the incident.

Review of the facility's Elopement Management Program policy dated 8/2022 revealed:
-Residents are to be assessed upon admission for risk of elopement, considering historical, diagnoses, orientation, and resident expressions of wanting to leave.
-Service plans include elopement precautionary plans, increased supervision frequency (especially the first 2 weeks of admission), door alarms, etc.
-At-risk residents and their care plans are to be communicated at all staff meetings.
-Staff is to immediately communicate when a resident was missing, and all staff were to begin searching inside and outside the property.

Review of Resident #1's current FL-2 dated 02/07/23 revealed:
-Diagnoses included muscle weakness, gait abnormalities, and leg and abdominal artery aortic aneurysm.
-Resident #1's orientation was not documented by the physician.
-He was semi-ambulatory.
-Level of care recommended was Assisted Living (AL).

Review of Resident #1's Resident Register dated 02/07/23 revealed:
-Resident #1 was admitted to the Assisted Living (AL) on 02/07/23.
-He had significant memory loss.
-He required 1-person assistance with ambulation, transfer,

dressing, and bathing assistance.

Review of Resident #1's Care Plan dated 02/12/23 revealed:
-Resident #1 had impaired cognition and verbal expression.
-He required cues, prompts, and step-by-step directions in decision making and preferred activities.
-He required 1 person assistance with toileting, bathing, grooming, and dressing.
-He required 1-person assistance to ambulate with a walker or wheelchair.
-He required a walker or staff assistance with transfers.
-He was a falls risk, due to a previous fall without injury, and required frequent supervision.
-He spent most days in his room.

Review of Resident #1's Incident/Accident (I/A) Report documented by the former Executive Director (ED) dated 06/14/23 revealed:
-Resident #1 did not have a dementia diagnosis or cognitive impairment.
-Resident #1 frequently sat outside on the facility front porch.
-Resident #1 was found across the busy city street on 06/14/23 at 07:00am.
-The Lead Medication Aide/Personal Care Aide (Lead MA/PCA) returned him to the facility (time not documented).
-Resident #1 reported he was going to the store.
-The Health & Wellness Nurse (HWN) assessed him and found no apparent injuries.
-Resident #1 was placed in the Special Care Unit (SCU) during the day, until a sitter was placed with him (dates not documented).
-The Power-of-Attorney (POA) was notified on 06/14/23 at 06:10am.
-The Primary Care Physician (PCP) was notified 06/14/23 at an undocumented time.

Review of Resident #1's Health & Wellness Nurse (HWN) Progress Note dated 02/10/23 at 7:01pm revealed Resident #1 reported he ambulated with a wheelchair.

Review of Resident #1's Progress Notes dated 04/03/23 and 04/08/23 revealed Resident #1 had a history of falls.

Review of Resident #1's Progress Note dated 04/23/23 at 09:48am revealed:
-Night staff found Resident #1 wandering the night of 04/22/23 (location not documented).
-The PCP was not documented as being notified of the

resident's night wandering behaviors.

Review of Resident #1's Progress Note dated 04/27/23 at 2:45pm revealed:
-Resident #1 had confusion and wandering behaviors.
-The PCP was not documented as being notified of the resident's night wandering behaviors.

Review of Resident #1's Progress Note by a HWN dated 05/04/23 at 12:30pm revealed:
-Resident #1 exhibited increased confusion.
-SCU placement would be considered if wandering behaviors and confusion continued.
-The PCP was not documented as being notified of the resident's night wandering behaviors.

Review of Resident #1's Progress Note dated 05/07/23 at 12:26am revealed:
-Resident #1 exhibited wandering behaviors (location not documented) and was redirected by staff.
-The PCP was not documented as being notified of the resident's night wandering behaviors.

Review of Resident #1's Progress Note dated 05/11/23 at 10:44am revealed:
-Resident #1 exhibited increased confusion and wandering behaviors the past month.
-The PCP was not documented as being notified of the resident's night wandering behaviors.

Review of Resident #1's progress note date 06/14/23 documented by a HWN at 08:00am revealed:
- Resident #1 wandered outside on 06/14/23 and was returned inside the facility (at undocumented times).
-Resident #1 reported he was going to the store.
-Resident #1 denied pain.
-The HWN assessed him and found no visible injuries.
-Resident #1 was moved to the facility's SCU for breakfast.

Interview with Resident #1's PCP on 10/17/23 at 1:15pm revealed:
-She was one of his treating PCPs.
-Resident #1 had a severe cognitive impairment.
-He had muscle weakness, poor mobility, and a history of falls.
-He had an aneurysm in his leg which could cause pain.
-With his cognitive challenges, she expected the facility to

provide secure memory care and direct supervision for Resident #1.
-She was not notified of Resident #1's wandering behaviors.
-Her office was not notified of Resident #1's elopement on 06/14/23.
-She expected their office to be notified of any incidents or change of condition for Resident #1.
-The facility did not request a physical evaluation of Resident #1 after his elopement on, or after, 06/14/23.
-The facility requested a urinalysis order on 06/26/23.
-The facility requested an FL-2 for SCU level of care on 06/27/23, due to disorientation, wandering, and a danger to himself.

Observation of the facility's front entrance lobby on 06/29/23 at 10:00am revealed:
-A staff member was stationed at a desk near the front doors.
-The lobby and concierge desk were constantly busy with staff, residents, providers, and visitors gathering, entering, and exiting.
-A large, double wooden door was locked until the Concierge or staff unlocked the door to enter or exit with a button or key panel coded it.
-All exit doors were locked until staff entered a code to unlock them for anyone entering or exiting.
-A second, external door automatically opened via sensor upon approach and held open for approximately 5 minutes without an audible alert.

Observation of the exit door by the salon on 10/10/23 at 11:00am revealed:
-The door opened, and its' alarm sounded, after pressing and holding the door's crash bar.
-The Lead MA/PCA arrived within minutes to respond.
-The alert was received on her pager.

Observation of the street area Resident #1 was found on revealed:
-The street in front of the facility was a busy 6-lane city road with a speed limit of 45 mph that intersected a traffic-signaled intersection with a 2nd, busy 6-lane road with a speed limit of 45 mph within approximately 350 feet.
-The right turn lane, where Resident #1 laid, had a curb, then a 4-foot-wide grass park strip, with a 4-foot-wide sidewalk with a 6-8-foot lawn on the other side.
-A large pond with a 10-foot drop rimmed with large stones was nearby.

Review of a map revealed the distance Resident #1 wandered from the facility to be 0.1 mile.

Review of the facility's exit doors' Alarm Reports revealed no facility exit door alarmed on 06/13/23 from 4:28pm to 06/14/23 at 9:14am.

Telephone interview with a city bus driver on 10/13/23 at 11:00am revealed:
-He drove a bus with passengers at 5:29am on 06/14/23 in the right-hand lane of the busy, 6-lane city street, across from the facility.
-It was still dark at 5:29am.
-As he approached the stop light, he was shocked to see a person lying on the side of the road, on the curb and grass park strip, so he pulled over at the intersection.
-He walked to the body and found Resident #1 laying on his back 'helpless" on the side of the road and park strip (a landscaped strip of land between a curb and sidewalk) with his walker tipped over the curb.
-Resident #1 had no visible injuries and was conscious.
-Resident #1 struggled but could not sit up or stand up.
-He assisted Resident #1 up to his feet and gave him his walker.
-He asked Resident #1 where he lived and where he was going.
-Resident #1 could not communicate his facility address.
-Resident #1 stated, he was going to the store for cigarettes.
-Resident #1 then tried to walk away with his walker.
off the curb into the street towards the side of the bus and fell into the driver, who moved in front of him.
-He caught and steadied Resident #1 and assisted him walk back to the park strip.
-He called his supervisor, who called Law Enforcement.
-Resident #1 tried to get on the bus, so the driver assisted him onto a seat on the bus.
-He stayed with Resident #1 for 1 hour, until Law Enforcement arrived at approximately 6:30am.
-Sometime around 7:00am, 2 facility staff arrived, spoke with Law Enforcement, and then took Resident #1.
-Resident #1 went willingly with the staff.

Review of city bus video dated 06/14/23 at 10:00am revealed:
-The bus driver drove immediately past Resident #1 lying on his back on the curb and park strip of a busy city road at 5:29am on 06/14/23.
-The bus driver pulled over ahead of Resident #1's location at the traffic lighted intersection of the 2 busy city roads.

-The bus driver walked down the sidewalk to Resident #1 lying on the curb and grass park strip along the road.
-Resident #1 laid on his back, unable to get up.
-The bus driver assisted Resident #1 up, steadied him, picked up and gave the resident his walker.
-The bus driver then walked along side Resident #1 to the bus.
-Resident #1 began walking off the curb with his walker, towards the side of the bus.
-The bus driver caught Resident #1 as he fell off the curb.
-The bus driver assisted Resident #1 onto a seat on the bus.
-The bus driver stayed with Resident #1.
-Arrival times for Law Enforcement and facility staff were no longer available on the videos.

Telephone interview with a Law Enforcement Officer 10/16/23 at 3:45pm revealed:
-A city bus driver called at 5:36am on 06/14/23 to report an elderly male walking on the busy city road.
-The Law Enforcement Officer who responded to Resident #1 was no longer with their department.

Interview with a facility Concierge on 06/29/23 at 10:00am revealed:
-The facility scheduled 2 Concierge shifts at the front door desk daily from 8:00am-2:00pm & 2:00pm-8:00pm that rotated.
-She did not work on 06/14/23.
-All facility exit doors were locked at all times.
-Exit doors could only be unlocked with each door's keypad.
-Exit doors lock automatically when closed.
-Resident #1 was first seen by the Concierge working on 06/14/23 sometime after she arrived for work at 8:00am.
-The Lead MA/PCA informed her Resident #1 had eloped and was returned by the Lead MA/PCA and the Dining Services Director (DSD) around 7:00am.

Attempted telephone interview on 06/29/23 at 10:15am with the Concierge who worked on 06/14/23 was unsuccessful.

Interview with a PCA on 06/29/23 at 1:45pm revealed:
-Resident #1 was very forgetful.
-He forgot his preferred activities, when to eat, and when and how to perform his personal care, so PCAs assisted him with his personal care (all Activities of Daily Living/ADLs).
-His supervision plan did not change from being checked every 2 hours.
-He did not go outside.
-She was not familiar with his Care Plan.

| | | |
|---|---|---|
| -Staff checked on him every 2 hours prior to 06/14/23 but did not document every check.<br>-She was not aware of any elopements or exit seeking behaviors prior to 06/14/23.<br>-Resident #1 usually ate breakfast in the dining room by the front door daily at 6:00am.<br>-She did not see him in the dining room for breakfast on 06/14/23. She did not see him until he returned with staff.<br>-Law Enforcement knocked on the facility front door on 06/14/23 at 6:36am to report a resident was sitting on a city bus across the street.<br>-The Dining Service Director (DSD) then left with the Lead MA/PCA to retrieve Resident #1.<br>-The staff did not know how he got out since all doors were code-locked.<br>-He returned without problem with the DSD and Lead MA/PCA.<br>-He had no visible injuries.<br>-The DSD immediately notified the ED and Assisted Living Coordinator (ALC) 6/14/23.<br>-The ED and ALC arrived at the facility at 9:05-9:15am.<br>-Resident #1 was placed in their SCU the next day, 06/15/23.<br>-Resident #1's family took him to an SCU at another facility 06/17/23.<br><br>Interview with a 2nd PCA on 09/14/23 at 1:20pm revealed:<br>-Resident #1 was confused so he needed supervision at all times.<br>-She had no knowledge of him exit seeking, eloping, or going outside prior to 06/14/23.<br>-She checked Resident #1 every 2 hours.<br>-He ate breakfast daily at 6:00am.<br>-She did not see him as usual in the dining room at or in his room between 6:15am-7:00am on 06/14/23.<br>-She was also getting other residents ready for breakfast from 6:15am-8:00am.<br>-She found him confused, sitting in his room chair when she checked on him upon his return at 7:00am on 06/14/23.<br>-He told her, he left 06/14/23 to buy cigarettes, but he did not smoke.<br>-She did not know how he got out of the facility on 06/14/23.<br><br>Interview with a 3rd MA/PCA on 10/24/23 at 4:29pm revealed:<br>-Resident #1 was confused and not oriented to person, place, or time.<br>-He would confuse day and nights and would need prompts and redirection for sleep, waking, preferred activities, and which meal came at each mealtime.<br>-He forgot when and how to appropriately perform his personal care and would urinate on the floor, so PCAs assisted him with all his personal care, all Activities of Daily | | |

| | | |
|---|---|---|
| Living (ADLs).<br>-Resident #1 was very forgetful, so they raised concerns about him safely being in AL to the former ALC, but he remained in AL.<br>-She last saw Resident #1 on 06/13/23 administering him medications sometime from 8:00pm-10:00pm.<br>-PCAs check residents every 2 hours during the night.<br><br>Interview with the Assisted Living Lead MA/PCA on 07/14/23 at 2:45pm revealed:<br>-Resident #1 required 1-person physical assistance with ambulation, transfers, toileting, bathing, dressing & grooming.<br>-Resident #1 required frequent supervision since he was confused and a falls risk.<br>-Staff were instructed to perform 2-hour checks on Resident #1 prior to 06/14/23.<br>-She decided to check on him every 20 minutes prior to 06/14/23, due to his confusion, forgetfulness, and falls history.<br>-She was unaware of him exit-seeking or eloping prior to 06/14/23.<br>-When she arrived to work 06/14/23 at 5:50am, it was still dark, and she did not see Resident #1 in his room or dining room.<br>-He usually ate breakfast in the dining room at 6:00am.<br>-She began readying other residents for the day and to take them down to breakfast.<br>-On 06/14/23, the DSD notified her at 6:30am, LE arrived to report a resident was on the city bus across the street.<br>-The facility doors were code-locked, and the door alarms did not audibly sound or alert their pagers that morning, as door alarms usually did.<br>-She drove with the DSD to the busy intersection to assist Resident #1 from the city bus and drove him back to the facility.<br>-He had no visible injuries.<br>-Resident #1 told them, he walked out the front door to go to the store to buy cigarettes.<br>-He reported, it was dark when he left the facility 06/14/23.<br>-He returned with her and the DSD without incident.<br>-She called the ALC and the corporate office 06/14/23 around 7:00am and notified them of the elopement.<br>-The DSD notified the ED of Resident #1's elopement and being found on the city bus 06/14/23 between 6:30am-7:00am.<br>-Staff did not know how he got out.<br>-The ground floor exit door by the salon was used by staff.<br>-When the exit door by the salon was opened in 2021, there was a delay in the door alarm sounding, so this door's alarm was repaired in 2021.<br>-She began to write the I/A Report, but the ALC said she would write the I/A Report and Progress Note, instead. | | |

-The ALC instructed her to take Resident #1 to the SCU immediately upon his return on 06/14/23.
-Family met with facility managers on 06/14/23.
-Family stayed with Resident #1 the night of 06/14/23.
-Resident #1 was transferred to a sister facility's SCU 1-2 days later.

Interview with the DSD on 09/14/23 at 10:00am revealed:
-Resident #1 was confused and had wandering behaviors.
-He arrived to cook on 06/14/23 around 5:30-6:00am.
-The Lead MA/PCA and a 2nd PCA arrived 06/14/23 at 6:00am.
-At 6:20am on 06/14/23, it was still dark outside when Law Enforcement knocked on the facility front door to report one of their residents was on the city bus across the street.
-He and the Lead MA/PCA drove and retrieved Resident #1 from the city bus and returned him to his AL room.
-Resident #1 appeared confused and without visible injuries.
-Resident #1 reported he went out the front door of the facility.
-He did not hear an exit door alarm but exit door alarms do not sound in the kitchen.
-Resident #1 reported, he was going to the store for cigarettes.
-Resident #1 was returned to his AL room; then taken to their SCU later on 06/14/23.
-He then notified the managers (ED, ALC, and RCD) on 06/14/23 between 6:30am-7:00am of Resident #1's elopement across the road and being found on a city bus.
-The ED transferred Resident #1 to their sister facility's SCU 2 days later on 06/17/23.

Review of Resident #1's Progress Note dated 06/14/23 at 1:45pm revealed:
-A HWN and the former RCD met with the resident's POA to notify her of Resident #1's increased confusion.
-Resident #1 remained disoriented and was not oriented to place.
-Family was informed, Resident #1 required increased supervision by family and sitters from 8:00pm – 8:00am, until a SCU bed became available.
-Resident #1 was not documented as being evaluated by his PCP or local Emergency Room (ER) after his 06/14/23 elopement.

Review of Resident #1's resident record revealed no Emergency Room treatment documentation was unavailable for Resident #1 after his elopement on 06/14/23.

Review of Resident #1's resident record revealed no PCP documentation of a physical evaluation of Resident #1 after his elopement on 06/14/23.

Interview with Resident #1's Power-of-Attorney (POA) 09/27/23 at 1:45pm revealed:
-Resident #1 was confused.
-He walked with a walker inside the facility prior to 06/14/23.
-The facility did not arrange a medical evaluation of Resident #1 after his elopement with a fall.
-The former ED and ALC gave her 5-6 hours to hire a sitter to stay with Resident #1 after his elopement on 06/14/23.
-The former ED was more concerned with the facility's liability, than Resident #1's dignified care transition and well-being.
-The former ED and former ALC's communications with the POA were limited and unresponsive.
-Resident #1 was sat in the common area of the facility's SCU without access to his belongings after the elopement.
-Family and sitters stayed nights with Resident #1.
-The facility had no SCU beds available, so the facility transferred Resident #1 to a sister facility SCU.
-Resident #1 told her, he went out the open exit door by the salon between the ground floor dining room and the SCU.
-She test-opened the exit door by the salon on 6/17/23; the door alarmed for 3 minutes, but no staff responded.
-The family moved Resident #1 to the facility's sister SCU on 06/17/23.
-She was not notified of Resident #1's increased confusion and indoor wandering behaviors until he eloped 06/14/23.

Telephone interview with a Family Member on 09/27/23 at 3:30pm revealed:
-Resident #1 had been declining cognitively and physically prior to his elopement.
-The ED and ALC reported, the resident eloped 06/14/23 around 6:00am and was returned by staff at 6:30am.
-He immediately came to see Resident #1 in his AL room after the elopement on 06/14/23 and supervised him from 8:00pm-6:00am.
-Resident #1 had 3, ½" cuts on his legs that bled onto his bed sheets.
-Resident #1 appeared tired, confused, and expressed remorse and guilt 06/14/23.
-Staff did not know how or when Resident #1 got out of the facility or what occurred to him.
-Resident #1 reported on 06/14/23, he was surprised to find the salon exit door open on 06/14/23, so he went out the door.
-Resident #1 reported, it was still dark when he left 06/14/23

as he left for the store for cigarettes. Resident #1 stopped smoking years ago.
-The ED and ALC called a meeting with family and Resident #1.
-Resident #1 told the ED, a city bus driver helped him up off the ground, but the ED did not address the resident's statement.
-The city bus driver told him, it was dark 06/14/23 when he stopped his bus when he saw Resident #1 lying in the road.
-The bus driver helped him up and into the bus until police arrived.
-The ED gave the family options of waiting 1 week for a SCU opening in their facility or discharging Resident #1 to their sister facility's SCU.
-The ED and ALC expected the family to pay for a sitter and supervise Resident #1 nights with him going to their SCU during the day, until the resident was placed in an SCU.
-The family then supervised Resident #1 nights in his AL room when Resident #1 was transferred to the facility's SCU the next day.
-Family moved Resident #1 to the facility's sister SCU on 06/27/23.

Attempted interview with the former Assisted Living Coordinator (ALC) working on 09/14/23 at 4:00pm was unsuccessful.

Attempted interview with the former Executive Director (ED) working on 09/14/23 at 4:05pm was unsuccessful.

Telephone interview with a facility nurse on 8/15/23 at 1:15pm revealed:
-Resident #1 was confused and needed more frequent supervision.
-Staff in his area were expected to check on Resident #1 to provide direct supervision.
-Resident #1 did not try to leave the facility before.
-She did not work 06/14/23.
-She saw the text from the DSD alerting all managers (ED, ALC, RCD) Resident #1 eloped across the street the morning of 06/14/23.
-The ED called the DSD back for information the morning of 06/14/23.
-The ED and ALC documented Resident #1 was sitting on the front porch, not that he eloped across the street.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

| | | |
|---|---|---|
| The facility failed to provide supervision for 1 of 7 residents (Residents #1) with severe dementia and wandering behavior residing in assisted living, who wandered unnoticed from the facility, across busy city street areas, fell over a curb, and laid on the side of the road unable to get up, resulting in significant physical fatigue, skin abrasions, confusion, and embarrassment. This failure resulted in injury and risk of death and constitutes a Type A1 Violation. | | |
| The facility provided a Plan of Protection in accordance for this violation on 09/14/23. | | |
| CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: 11/29/23. | | |
| | | |

| | | |
|---|---|---|
| **IV. Delivered Via:** | Electronically Submitted | Date: 10/30/23 |
| **DSS Signature:** | *Roberta Schmidt-Beebe* | **Signed CAR Due: 10/30/23** |

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

| | | |
|---|---|---|
| **VI. Plan of Correction Submitted by:** | Administrator (print name): | |
| ***POC DUE: 11/20/23*** | 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.* | | | |