# Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Addison of Indian Trail
Address: 5306 Secrest Short Cut Road, Monroe, NC
County: Union
License Number: HAL-090-035____
II. Date(s) of Visit(s): 10/2/24, 10/3/24, 10/9/24, 10/18/24, & 10/24/24
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 11/08/24

**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 CAR. 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, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)*<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**<br><br>12/02/24 |
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| Rule/Statute Number: 10A NCAC 13F .0902(b) HEALTH CARE<br>_____ | ☒ POC Accepted<br>_____ *DSS Initials* | ____<br>. : |
| Rule/Statutory Reference:<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. | 10A NCAC 13 F..0902(b) | |
| Level of Non-Compliance: TYPE A1 VIOLATION | | |
| Findings:<br>The rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to provide 1 of 5 sampled residents (#1) medical assistance for a resident with a diagnosis of dementia who complained of abdominal and back pain on numerous occasions throughout the day, after being mishandled by a staff member and an unwitnessed fall.<br><br>The findings are:<br>Review of Resident #1's current FL-2 dated 09/18/24 revealed:<br>-Diagnoses included dementia, hypertension, chronic fatigue unspecified, and anxiety disorder.<br>-Resident #1's level of care was for a Special Care Unit (SCU). | Training of fall response will be provided to MTs and PCAs to ensure all falls, witnessed or unwitnessed, will be reported in community to HWD, MCD, RCC and ED for further actions.<br>Responsible Persons: HWD, RCC, MCD and ED | 11.20/20 24 & ongoing |

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| Review of Resident #1's current care plan dated 09/16/24 revealed:<br>-Resident #1 had a moderate memory impairment and required directions and reminders from others as well as supervision and oversight for safety.<br>-Resident #1's level of assistance was independent for escorts as Resident #1 did not require assistance with escorting.<br>-Resident #1 was independent with mobility/ambulation.<br>-For the fall potential category, Resident #1 was to be monitored for falls and falls were to be reported to appropriate team members.<br><br>Review of the Incident Report for Resident #1 received to the County Department of Social Services (DSS) on 10/01/24 at 4:35pm revealed:<br>-The date and time of incident was documented as 8:15pm on 09/30/24.<br>-The responsible party was notified on 09/30/24 at 8:15pm<br>-The medical provider was notified on 10/01/24 at 10:50am.<br>-Resident #1 complained of pain/discomfort of the back.<br>-The responsible party, Special Care Director and the Administrator was notified.<br>-The responsible party requested for Resident #1 to be sent out to the emergency department.<br><br>Review of an addendum to the Incident Report dated 10/01/24 provided to the Adult Home Specialist on 10/02/24 at 3:30pm revealed:<br>-On 09/30/24 at 9:30am, a staff member came up behind Resident #1 and grabbed Resident #1 under the arms and took Resident #1 out of the dining room.<br>-A medication aide (MA) observed Resident #1 sitting on her buttocks by the medication cart.<br>-At 10:35am, the Special Care Director observed Resident #1 in the dining room with her head on the table, Resident #1 stated "her back hurts".<br><br>Review of the Emergency Medical Services (EMS) Report for Resident #1 on 09/30/24 revealed:<br>-The time of call for emergency services was made at 7:00pm.<br>-The chief complaint was for back pain and the secondary complaint was for abdominal pain.<br>-Upon EMS arrival, Resident #1 was conscious to her normal, and had a history of dementia.<br>-Facility Staff stated that Resident #1 complained of back pain, side pain and abdominal pain. | 24h communication book will be reinforced in community: Residents' condition changes including pain, falls, refusal of meals, refusal medications will be communicated in 24h communication books and passed to management in stand-ups every morning and as needed to address any issues. Responsible Persons: HWD/MCD/ED<br><br>PCP Notification will be reinforced in community: Resident' urgent condition changes including falls with pain, newly onset signs or symptoms, newly changed ADL's, refusal of medications, refusal of foods etc. will be passed to primary care provider or clinical on call manager for further instructions if PCP is not immediately available. This is included in training in health care. Responsible Persons: HWD/ED/RCC | 11/20 2024 &ong oing<br><br>11/20/20 24& ongoing |

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| -EMS observed that Resident #1 was unable to stand without assistance.<br>-Staff reported that Resident #1 was normally up walking around.<br>-EMS notated that Resident #1 stated that her back and abdomen hurt and did grimace with palpation.<br><br>Review of emergency room hospital medical records for Resident #1 revealed:<br>-On 9/30/24 at 9:58pm, Resident #1 was seen in the emergency room by a physician.<br>-Chief complaint was for flank pain and altered mental status.<br>-Records stated Resident #1 was sent from facility where she was noted to be altered throughout the day today.<br>-Facility reported that Resident #1 was typically oriented and able to walk but she had been unable to do either today.<br>-Facility also reported Resident #1 complained of flank pain.<br>-Resident #1 stated "she hurts all over".<br>-Resident #1 appeared significantly confused with nonsensical speech.<br>-Resident #1 appeared to be diffusely tender to palpation throughout her abdomen.<br>-A CT abdomen pelvis of Resident #1 showed evidence of acute right eighth, and ninth rib fractures.<br>-The responsible party for Resident #1 was contacted and stated that he was told by the facility that Resident #1 fell and was found on the ground in her room.<br>-This was not told to the medic on their arrival and not told in the medic report.<br>-Resident #1's responsible party also conveyed that Resident #1 had some confusion but was typically more oriented and able to hold a conversation.<br>-Resident #1 appeared to be more confused than her normal baseline.<br>-CT chest imaging was obtained and showed eighth, ninth and tenth rib fractures with small hemothorax (an accumulation of blood within the pleural cavity).<br>-Trauma surgery was consulted and was willing to accept Resident #1 for surgery if responsible party agreed.<br>-Responsible party decided on pain control as alternative to surgery.<br>-Problems addressed was closed fracture of multiple ribs of right side, initial encounter: complicated acute illness or injury Fall.<br><br>Interview with a first shift personal care aide (PCA) on 10/03/24 at 1:26pm revealed:<br>-She was working in the special care unit on 09/30/24. | Clinical On-Call manager for each week will be posted in community with manager's name, contact information and what situations will be called for guidance on community's daily schedules.<br><br>Training in state regulations and requirements in health care will be provided to MTs and PCAs on by HWD and ED. | 11/20/24<br>I&<br>ongoing<br><br>11/20/24<br>I.&<br>ongoing |

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| -She cautioned another PCA that Resident #1 had became aggressive with her on the previous day (09/29/24) and had scratched her.<br>-The PCA responded that Resident #1 was not going to be doing that to her.<br>-The same PCA went over to Resident #1 and started knit-picking with Resident #1 in the dining room where breakfast was being served.<br>-She recalled that Resident #1 was not doing anything when she was approached by the PCA, and she did not hear Resident #1 say anything.<br>-She observed the PCA yank Resident #1 up from behind and pulled her out of the room.<br>-The PCA elaborated that the PCA had put her arms under the arms of Resident #1 from behind. The PCA forced Resident #1 into the hallway. | | |
| -She saw the PCA push Resident #1 once out of the dining room and stated, "I don't care if she falls".<br>-The incident occurred at 8:30am while they were preparing for breakfast.<br>-After the incident, Resident #1 said her back was hurting.<br>-On 09/30/24 at 10:30am she and another PCA who witnessed the incident, reported the incident to the Administrator as Resident #1 was still in pain and could barely walk.<br>-She told the Administrator what had occurred which included Resident #1 being pushed by the PCA.<br><br>Interview with another first shift PCA on 10/18/24 at 11:25am revealed:<br>-She was working in the dining in the special care unit on 09/30/24.<br>-She and two other PCA's were setting the tables and setting up breakfast around 7:30am.<br>-She observed Resident #1 walk into the dining room perfectly fine.<br>-She recalled that a PCA went up to Resident #1 and said, "I am not doing this (expletive) today" followed by the statement "Get your (expletive) up".<br>-The PCA was standing behind Resident #1 and picked Resident #1's whole body up as Resident #1's feet were off the floor.<br>-The PCA took Resident #1 around the corner and immediately after a MA stated that Resident #1 had fallen.<br>-She observed Resident #1 on the floor near the towel cabinet door and employee bathroom on the memory care unit.<br>-The PCA who had lifted Resident #1 out of the dining room assisted with Resident #1 being brought to the dining room after the fall. | | |

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| -She and another PCA reported the incident to the Administrator after it occurred, approximately at 10:30am.<br>-When she returned to the dining room area, Resident #1 was crying and could not move. Resident #1 stated that her back hurt.<br>-Resident #1 cried for a while and then fell asleep.<br>-Resident #1 would not eat any of her food.<br>-When she saw Resident #1 later in her shift, she thought it was odd that Resident #1 was still sitting in the dining room and had not been sent out for medical attention.<br>-It appeared that no one took the incident seriously.<br><br>Interview with a first shift medication aide on 10/09/24 at 12:20pm revealed:<br>-She was working the medication cart on 09/30/24.<br>-At around 8:15am she heard Resident #1 saying "somebody was trying to kill her".<br>-She also overheard a PCA make the statement "not today".<br>-She observed a PCA to have Resident #1 lifted off the floor with her arms underneath the arms of Resident #1.<br>-The PCA took Resident #1 near the toilet tissue cabinet and employee bathroom located in the special care unit.<br>-When she turned around, she observed that Resident #1 may have fallen backwards as she was positioned on her right side on the edge of the wall.<br>-After the incident, Resident #1 said she did not want to eat and that she was in pain.<br>-The Special Care Director was made aware and stated she would inform the Administrator.<br>-She recalled that around 1:45pm, Resident #1 still complained that her back hurt. Resident #1 continued to complain about the same spot on her right side.<br>-At 2:00pm, the occupational therapist came and was able to assist Resident #1 to stand up.<br>-The second shift staff called the ambulance.<br>-She was not sure as to why the ambulance had not been called on first shift when Resident #1 was injured and complained of pain.<br><br>Interview with another first shift MA on 10/03/24 at 1:06pm revealed:<br>-She was working the medication cart in the special care unit on 09/30/24.<br>-The PCA's were getting residents ready for breakfast.<br>-Another MA told her to look because Resident #1 was on the floor.<br>-She went and assessed Resident #1 around 8:15am-8:30am. | | |

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| -She recalled Resident #1 told the special care director after the incident that her back was hurting.<br>-The special care director informed the Administrator who in turn called the responsible party for Resident #1.<br>-Resident #1 did not have any prior back pain or injuries.<br>-The occupational therapist came later that afternoon and visited with Resident #1.<br><br>Review of Home Health Records for a visit completed by the occupational therapist with Resident #1 on 09/30/24 at 2:02pm revealed:<br>-Resident #1 was seen on 09/30/24 for a routine visit.<br>-Resident #1 started receiving occupational therapy services on 09/13/24.<br>-For breathing: Resident #1 occasional labored breathing and a short period of hyperventilation. | | |
| -For vocalization: Resident #1 had repeated trouble calling out, loud moaning or groaning and crying.<br>-Resident #1 displayed facial grimacing.<br>-Resident #1 was holding her left hand in fist as if in pain.<br>-Resident #1 was difficult to console and comfort.<br>-Resident #1 was holding right flank.<br>-Resident #1 was complaining of pain in her right flank.<br>-Resident #1 had no signs of bruising or injury.<br>-Staff denied that Resident # 1 had a fall.<br>-It was noted that Resident #1 had new pain from prior visits that Resident #1 was unable to describe.<br>-She notified staff during the visit about the new onset of pain of right flank for Resident #1.<br>-Staff reported that they had been unable to get Resident #1 to stand up from the table since lunch.<br>-Staff reported that Resident #1 had become increasingly aggressive and had sat down on the floor that morning and it took staff an extended period of time to get client to stand up.<br>-Notes indicated extensive education to staff and the special care director on the changes with Resident #1 since the last visit. They reported they were aware and had notified the community physician.<br>-The outcome of the visit was Resident #1 observed with decline and function from the prior week and appeared to be in pain.<br><br>Interview with the Occupational Therapist for Resident #1 on 10/28/24 at 4:45pm revealed:<br>-She had a visit with Resident #1 on 09/30/24 in the afternoon.<br>-She recalled the visit was after lunch and Resident #1 was sitting in the dining room when she started the visit.<br>-Resident #1 was not able to stand up on her own. | | |

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| -She assisted Resident #1 with standing up and took her back to her room.<br>-She observed that Resident #1 appeared to be in pain as she was holding her right side.<br>-Resident #1 was holding her hand in a fist which is a sign of being in pain.<br>-She informed the Medication Aide of the changes with Resident #1 on this date.<br>-She also spoke with the special care director about her observations of Resident #1 on this date.<br>-The special care director responded that she was aware of the situation and would be consulting with the administrator and the health and wellness director.<br>-The special care director also stated that Resident #1's medical provider had already been notified.<br>-She specifically asked staff if Resident #1 had a fall, and staff denied this to be the case.<br><br>Telephone interview with the primary care provider (PCP) for Resident #1 on 10/28/24 at 2:10pm revealed:<br>-He was not contacted on 09/30/24 in reference to any medical issues or pain Resident #1 experienced.<br>-The facility sent an email communication on 10/01/24 at 12:25pm that Resident #1 had been transferred to the hospital on 09/30/24.<br>-Resident #1 was new to the community and he had only met with her once on 09/11/24 to establish care.<br>-A referral was made for physical and occupational therapy to reduce fall risk for Resident #1.<br>-The facility had not made him aware of any new medical or behavioral concerns as to Resident #1.<br>-He was not at the facility on 09/30/24, he returned on 10/02/24 for visits with residents, Resident #1 was still at the hospital.<br>- If he had been consulted about Resident #1's condition on 09/30/24 of being in pain due to alleged abuse allegations and/or an unwitnessed fall he would have recommended for Resident #1 to be sent to the hospital.<br><br>Telephone interview with a second shift PCA on 10/25/24 at 4:15pm revealed:<br>-She worked on 09/30/24 and started her shift at 3:00pm.<br>-First shift had conveyed during rounds that Resident #1 had not been feeling well.<br>-She was told by first shift staff that Resident #1's stomach was bothering her.<br>-She tried to get Resident #1 to come to dinner but Resident #1 refused to eat. | | |

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| -She observed Resident #1 to be hunched over in her chair and screeched over in pain when she leaned over.<br>-Resident #1 told her that her back and stomach hurt.<br>-When Resident #1 would sit up the pain was worse.<br>-It was obvious to her that Resident #1 had more than a stomach bug.<br>-She went to get the MA who also observed the pain that Resident #1 experienced.<br>-She and the medication aide sent Resident #1 out to the hospital around 7:00pm.<br>-The responsible party, Administrator and special care director were all notified.<br>-She denied having any issues with Resident #1 and stated that Resident #1 was very compliant.<br>-Resident #1 was normally talkative and would be up walking around. | | |
| Telephone interview with a second shift MA on 10/21/24 at 10:18am revealed:<br>-She began her shift at 3:00pm on 09/30/24.<br>-She was told by the first shift medication aide that Resident #1 had been combative and was not feeling well.<br>-The PCA was working with Resident #1 when second shift began.<br>-The PCA brought Resident #1 food, but she would not eat her food.<br>-She examined Resident #1 and when she touched her on her back, Resident #1 was screaming. Resident #1 stated "oh my god, it hurts".<br>-She also touched Resident #1 on the lower stomach and Resident #1 told her it was hurting as well.<br>-She contacted the responsible party for Resident #1, and he informed her that the administrator and the special care director had told him earlier that Resident #1 was fine.<br>-She told the responsible party that Resident #1 was in excruciating pain and was being sent out to the hospital.<br>-She also notified the administrator and the special care director.<br>-She never had any issues with Resident #1 and indicated that Resident #1 was mainly compliant.<br><br>Interview with the Special Care Director (SCD) on 10/03/24 at 1:57pm revealed:<br>-On 09/30/24 upon her arrival at 8:30am, she had a huddle with staff who reported that Resident #1 had acted out and showed extreme behaviors.<br>-She observed Resident #1 sitting in the dining room with her head down. | | |

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| -Around 10:30am and 11:00am the Administrator requested for her to check on Resident #1.<br>-Resident #1 was in the same position with her head down and held her head up and said "she was hurting".<br>-Resident #1 motioned to her back as to where she hurt, she lifted Resident #1's shirt up and noticed Resident #1 was sensitive to touch in that area.<br>-She indicated that she informed the Administrator of her findings.<br>-Resident #1 remained in the dining room as she could not move.<br>-The Occupational Therapist visited with Resident #1 and informed her that she could not get Resident #1 to do anything.<br>-She and the Administrator contacted the responsible party and informed him that Resident #1 complained of back pain.<br>-The responsible party was not made aware of all the events/details that occurred as to Resident #1 on this date.<br>-She did not seek medical attention for Resident #1, because Resident #1 always complained about "this or that".<br><br>Telephone interview with Resident #1's responsible party on 10/21/24 at 11:23am revealed:<br>-On 09/30/24 the Administrator and the special care director informed him that Resident #1 had fallen.<br>-The facility did not mention an incident with staff had occurred, only that Resident #1 had fallen.<br>-He agreed that Resident #1 could be monitored instead of sent to the hospital.<br>-If he had been provided with all the information that occurred to Resident #1 and repeated complaints of pain on 09/30/24 he would have requested for Resident #1 be sent to the hospital instead of being monitored.<br>-He was contacted later in the evening and was told that Resident #1 was sent to the hospital.<br>-He was informed by the hospital that Resident #1 had three rib fractures and surgery was offered although he opted not to do so.<br>-The facility informed him on 10/01/24 that something occurred in the dining with Resident #1 and a staff member.<br><br>Interview with the Health and Wellness Director (HWD) on 10/24/24 at 1:48pm revealed:<br>-She was not present on 09/30/24.<br>-She returned on 10/01/24 and participated in investigative interviews with staff regarding Resident #1 and a staff member. | | |

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| -She became concerned about the nature of the statements from staff that indicated that a PCA had placed her arms under the arms of Resident #1 and mishandled her.<br>-She contacted the hospital on 10/01/24 and was informed that Resident #1 had three rib fractures and would possibly be sent to the trauma center in another county.<br>-She sent an email communication to the PCP on 10/01/24 that Resident #1 was at the hospital.<br>-When a resident complained of pain they were sent to the hospital, or the PCP was contacted for directives.<br>-She learned that contact had not been made with DSS. She and the Administrator contacted the adult home specialist on 10/01/24 at 5:15pm about Resident #1 being mishandled by a staff member.<br>-Law Enforcement was also contacted on 10/01/24 and arrived at 6:20pm and took an abuse report as to Resident #1.<br><br>Review of the 24-Hour Incident Report sent to the Health Care Personnel Registry dated 10/02/24 revealed:<br>-The incident date and time was documented as 09/30/24 at 9:00am.<br>-A team member forcibly removed Resident #1 from the dining room.<br>-Resident #1 was observed on the floor and assessed.<br>-Upon first assessment of Resident #1, there was no indication of injury.<br>-Resident #1 later expressed pain.<br>-The community contacted the responsible party and offered for Resident #1 to be sent out for emergency room evaluation, but the responsible party declined.<br>-Resident #1 exhibited heightened discomfort in the evening and was sent out to the emergency room for evaluation.<br><br>Interview with the Administrator on 10/02/24 at 4:30pm revealed:<br>-On 09/30/24 at 10:30am two PCA's spoke with her about another PCA being too rough with Resident #1.<br>-One PCA told her that Resident #1 was told to get up and leave the dining room. Afterwards the same PCA witnessed Resident #1 being pushed to the ground after she was taken out of the dining room.<br>-Another PCA informed her that the PCA had put her arms underneath the arms of the arms of Resident #1 and removed her from the dining room.<br>-Both PCAs conveyed that the incident occurred at 8:15am.<br>-She spoke with a MA who reported she did not see anything, only Resident #1 sitting on the floor. | | |

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| -A quick physical assessment was completed of Resident #1 by a MA and no injuries were found. Resident #1 stated she was okay.<br>-She did not seek medical attention for Resident #1 because Resident #1 did not have any visible injuries.<br>-She interviewed the PCA who was alleged to have mishandled Resident #1. The PCA stated that she was trying to redirect Resident #1 who was disruptive. The PCA did not know why Resident #1 was on the floor. The PCA acknowledged she went behind Resident #1 to move her out of the dining room.<br>-She learned from interviews with staff that the PCA had stated "I am not dealing with this (expletive) today" and then went behind Resident #1 to remove her from the dining room.<br>-She spoke with the responsible party on 09/30/24 and did not make him aware that Resident #1 had been improperly handled by a staff member and the current investigation into the incident.<br>-The responsible party was made aware that Resident #1 had a fall.<br>-The facility inquired if the responsible party would like to wait for Resident #1 to be seen by the medical provider or to be sent to the hospital. The responsible party was okay with Resident #1 waiting to be seen by the medical provider the next time when the medical provider was on-site.<br>-The responsible party was informed of an investigation regarding the incident with Resident #1 and an employee on 10/01/24.<br>-Resident #1's medical provider was not contacted on 09/30/24 regarding the incident for guidance/recommendations.<br>-She gave no explanation as to why Resident #1's primary care provider was not contacted.<br>-On 09/30/24 at 7:00pm, the medication aide notified her that Resident #1 was being sent out as she refused a shower and groaned of pain.<br>-She had not communicated with second shift staff about the incident or a fall by Resident #1.<br>-She did not notify the hospital of the incident or a fall by Resident #1.<br>-She received the update on the morning of 10/01/24 that Resident #1 had rib fractures.<br>-She worked on the 24-hour incident report.<br>-She and the Health and Wellness Director spoke with the adult home specialist with the local DSS on the evening of 10/01/24 at 5:15pm.<br>-Law Enforcement was contacted on 10/01/24 by the Health and Wellness after contact with DSS. | | |

Facility Name:

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| The facility failed to ensure Resident #1, who had a diagnosis of dementia and repeatedly complained of right flank pain was provided with medical assistance after being mishandled by an employee and a subsequent immediate unwitnessed fall. This failure resulted in the resident not receiving timely medical treatment and being admitted to the hospital for three rib fractures and a hemothorax and altered mental status. This failure resulted in serious neglect and serious physical harm which constitutes a Type A1 Violation. | | |
| The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/24 for this violation | | |
| THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2024. | | |

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| **IV. Delivered Via:** | Hand Delivered | Date: 11/8/24 |
| **DSS Signature:** | Rosa Lyn Hollar | Return to DSS By: 12/2/24 |

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| **V. CAR Received by:** | Administrator/Designee (print name): TARA BENSON | |
| | Signature: Tara Benson | Date: 11/8/24 |
| | Title: Executive Director | |

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| **VI. Plan of Correction Submitted by:** | Administrator (print name): TARA BENSON | |
| | Signature: Tara Benson | Date: 11/20/24 |

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

Facility Name:

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| ☒ *POC Accepted* | By: Gwendolyn Hall Date: 11-20-24 |
| Comments: | |

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| **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.*