Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Haywood Lodge and Retirement
Address: 251 Shelton St. Waynesville, NC 28786
County: Haywood
License Number: HAL-044-009

II. Date(s) of Visit(s): 4/28/25-5/2/25
Purpose of Visit(s): Complaint
Exit/Report Date: 6/9/25

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 .0902 HEALTH CARE

☒ POC Accepted AG 7-10-25
DSS Initials

Rule/Statutory Reference: 10A NCAC 13F .0902 HEALTH CARE (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

Level of Non-Compliance: Type A2 Violation

Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 11 sampled residents received referral and follow-up to meet the routine and acute health care needs related to prolapse uterus (Resident #1) and rectal prolapse (Resident #11).

Findings:

1. Review of Resident #1's current FL-2 dated 5/30/24 revealed:
-Diagnoses included hypothyroidism, cognitive impairment, left bundle branch block, and gastroesophageal reflux disease (GERD).
-She was ambulatory with the assistance of a walker.
-She was intermittently disoriented.

Review of Resident #1's Care Plan dated 6/14/24 revealed there was no documentation of treatment for reoccurring uterine prolapse.

new updated Care Plan 6/16/25 with documentation of uterine/rectum prolapse documentation on it with PCP signature.

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 3/17/25 revealed there was no documentation for staff to provide care for reoccurring uterine prolapse.

Review of Resident #1's care note dated 6/18/23 revealed:
-There was documentation at 8:12am the resident was observed with large hard mass out of vagina. Resident was sent out by EMS (emergency medical services) and transported to ER (emergency room) for further evaluation.
- There was documentation at 9:13am the resident was transferred back to the facility with a diagnosis of a "prolapsed uterus".
-To make appointment with obstetrician-gynecologist (OBGYN) for uterine prolapse.

Review of Resident #1's hospital discharge instructions dated 6/18/23 revealed instructions to schedule a follow up appointment with OBGYN provider for uterine prolapse.

Review of Resident #1's care note dated 6/19/23 revealed a follow up appointment for uterine prolapse was scheduled with an OBGYN on 7/27/23 at 1:45pm.

Interview with a representative from the OBGYN office on 5/2/25 at 9:04am revealed:
-Resident #1 had an appointment scheduled for 7/23/23
-The appointment scheduled for 07/23/23 was cancelled by the facility.
-Resident #1 was not a patient and had not been seen by any provider at the office.

Appointment was cancelled per family request.

Interview with a personal care aide (PCA) on 4/28/25 at 2:36pm revealed:
-A week ago, Resident 1's uterus prolapsed, and she observed the medication aide (MA) "push" the uterus back into Resident #1's vagina.

Interview with a MA on 4/28/25 at 2:45pm revealed:
-Resident #1 had experienced prolapse recurrence of the uterus since she was admitted to the facility on 5/30/23.
-She assisted Resident #1 with her uterine prolapse "about 3 times" each month.
-Resident #1 would let her know when her uterus was prolapsed, and she provided care to correct the issue.
-Resident #1 would lay on her bed naked from the waist down, and with a gloved hand she would "push" Resident #1's uterus back inside her body through her vagina.

-The Resident Care Coordinator (RCC) showed her how to correct the prolapse sometime around 6/2023."
-All MA's were trained by the RCC to push Resident #1's uterus "back in" when it prolapsed.
-Resident #1 was not sent to the ER or any outside provider for treatment of her prolapsed uterus.
-She assumed Resident #1 was not being sent out for treatment was because her family declined surgery needed to prevent the uterus from prolapsing.
-She did not document when she corrected Resident #1's uterine prolapse.
-She informed the RCC whenever she had to push Resident#1's uterus back in, but she did no notify the facility's Nurse Practitioner.

Interview with a second MA on 4/30/25 at 2:10pm revealed:
-She had reinserted Resident #1's prolapsed uterus.
-Resident #1's uterus looked like a large mass about the size of a grapefruit that came out of the vagina.
-Resident #1 had notified her when she needed assistance with her uterus.
-In the last 60 days, Resident #1 would lay on her bed and she "pushed" the uterus back in.
-She has pushed Resident #1's uterus "back in about 3 times in the last 2 months."
-Resident #1 had not been sent out for treatment of the prolapsed uterus.
-She did not know how often Resident #1 needed care for uterine prolapse because first and third shift had not communicated how often each of them pushed the uterus back in.
-She did not document when she pushed Resident #1's uterus back in and did not notify the facility's Nurse Practitioner.

Interview with a third MA on 5/1/25 at 11:00am revealed:
-Resident #1 suffered from reoccurring uterine prolapse.
-She knew when Resident #1 required treatment for prolapse because "she could smell it."
-She had pushed Resident #1's uterus back into her vagina two times while being employed at the facility.
-The RCC showed her how to correct the prolapse.
-About a week ago, Resident #1 experienced prolapse. She attempted to push the uterus back in through the vagina, but the uterus would not go back in.
-She called the RCC and the RCC told she would come and get the uterus "back in" later.
-She did not know how long Resident #1 had to wait for the RCC to come and assist her.
-She assumed the RCC's attempt was "successful" because

All staff was informed 6/9/25 they were not qualified to push prolapsed uterus or prolapsed rectum in. They were to call provider if she could not come then take them to Jackson medical Associates and if Jackson medical associates were unavailable to take residents to ER.

the following day when she returned to work the uterus was back in.
-She did not document any care she provided for Resident #1's uterine prolapse because no one had instructed her to do so.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #1's reoccurring uterine prolapse.
-Resident #1 was hospitalized in 2023 for a prolapsed uterus, and treatment would include corrective surgery to tack the uterus which would prevent future prolapses.
- Resident #1's family declined the surgery.
-Resident #1's uterus prolapsed "about once a month."
-She "trained" all the MA's on how to reinsert Resident #1's uterus.
-Resident #1 would lay down on the bed, and with a gloved hand she pushed Resident #1's uterus "on all sides, and it goes back in."
-She had "always been able to get the uterus to go back in".
-There was no need to notify the facility's Nurse Practitioner because there was "nothing they could do".
-She did not think it was necessary "to send Resident #1 to the hospital because she has always been successful with getting the uterus to go back in."

Interview with facility LHPS nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #1 suffered from uterine prolapse.
-Reinsertion of uterine prolapse was not a task MAs could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a prolapsed uterus was not a task for an aide to perform.
-She was "nervous" the facility allowed staff to perform this task.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was aware that Resident #1 had a history of uterine prolapse.
-She was not aware that Resident #1 experienced recurring or a recent prolapse of her uterus.
-She remembered Resident #1 would need surgery to correct

Provider will Check RCC off on proper Sterile Procedure to push prolapse uterus / prolapse rectum back in place. If unavailable or unable to do successfully will call provider and send to Jackson medical Associates. If they are unavailable, resident will be Sent to ER for treatment 6/16/25

her uterine prolapse, but this was not recommended because she would not recover well.
-She did not know staff were "correcting" Resident #1's uterine prolapse.
-She was concerned staff were treating Resident #1's uterine prolapse and this was a "problem" because staff had not communicated Resident #1's health care needs to her.
-She was not aware this was a current problem, and staff should have told her.
-She was concerned that staff had not told her Resident #1 was experiencing recurring uterine prolapse.
-She did not train the RCC or any staff on how to manage Resident #1's uterine prolapse.
-Staff should not manage Resident #1's uterine prolapse.
-Resident #1 should be seen by her or be sent out to the hospital.
-She was "worried" Resident #1 could be prolapsed and needed medical treatment.

2. Review of Resident #11's current FL-2 dated 7/3/24 revealed:
-Diagnoses included mild dementia, hearing loss, depression, and spinal stenosis.
-She was semi-ambulatory with the assistance of a walker.
-She was intermittently disoriented.
-Incontinence of bowel and bladder.

Review of Resident #1's Care Plan dated 9/2/24 revealed there was no documentation related to a rectal prolapse.

Review of Resident #11's Licensed Health Professional Support (LHPS) review dated 1/3/25 revealed there was no documentation for staff to provide care for reoccurring rectal prolapse.

Review of Resident #11's care note dated 3/16/23 revealed:
-Resident #11 stated her rectum was out.
-Resident #11's rectum was observed out with blood.
-Resident Care Coordinator (RCC) instructed to send out Resident #11.
-Resident #11 returned to the facility with no new orders.

Review of Resident #11's hospital discharge instructions dated 3/16/23 revealed:
-Rectal prolapse was a condition that caused the rectum to come through the anus. A prolapse may happen during a bowel movement.
-Instructions to schedule a follow up appointment with a general surgeon to explore surgical interventions for recurrent

rectal prolapse.

Review of Resident #11's care note dated 10/30/23 revealed:
-Resident #11 complained of rectum falling out.
-Two staff, one of whom was a female aide, went to observe Resident #11.
-Resident #11's rectum was pushed back in.
-The resident was laying and resting.

Review of Resident #11's care note dated 5/7/24 revealed:
-Resident #11 stated her rectum fell out.
-The medication aide (MA) and personal care aide (PCA) pushed rectum back in.

Interview with a MA on 4/30/25 at 2:10pm revealed:
-Resident #11 experienced recurring rectal prolapse.
-She was trained by another MA and had pushed Resident #11's rectum "back in several times".

Interview with second MA on 5/2/25 at 8:45am revealed:
- Resident #11 experienced recurring rectal prolapse.
-The resident had experienced rectal prolapse for almost two years.
-She corrected the rectal prolapse on "6 separate occasions".
-Resident #11 had hemorrhoids and constipation and this was treated by pushing fluids and stool softeners.
-The RCC showed her how to push in Resident #11's rectum.
-All MA's were trained on how to push in Resident #11's rectum.

Interview with a PCA on 4/30/25 at 4:25pm revealed:
-Resident #11 experienced rectal prolapse.
-She observed Resident #11's rectal prolapsed when providing her assistance with showers.
-About a week ago, Resident #11 came to her saying her bottom burned and she was not able to have a bowel movement.
-She looked at Resident #11 and her rectum was out about 3 to 4 inches long and it was bright red.
-She informed the MA and "the MA pushed the rectum back in".
-The MA pushed the rectum back in while Resident #11 was standing.
-Resident #11 stated her bottom was burning and painful, but felt better after the rectum was pushed back in.

Interview with a second PCA on 5/1/25 at 8:48am revealed:
-When Resident #11 experienced rectal prolapse, she would say "my butt is hanging out".

-Resident #11 had experienced recurring rectal prolapse for a couple of years.
-The MAs corrected the prolapse and she had seen this done about 5-6 times.
-The MAs would put petroleum jelly on their gloved hands and push Resident #11's rectum "back in".
-In the past, Resident #11 complained of stomach pain and constipation.
-She had observed Resident #11's rectal prolapse and it was "very bright" red and about 3 to 4 inches long.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #11's recurring rectal prolapse.
-Resident #11 was hospitalized in 2023 for a prolapsed rectum, and treatment would include corrective surgery to prevent future prolapses.
-The surgeon did not recommend surgery because she did not think Resident #11 would be able to recover.
-She "trained" all the MAs on how to reinsert Resident #11's rectum and she learned how to correct prolapses from the facility Nurse Practitioner.
-She did not think it was necessary to send Resident #11 to the hospital because "there was nothing they could do".

Interview with facility Licensed Health Professional Support (LHPS) nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #11 experienced recurring rectal prolapse.
-A rectal prolapse was not a task any aide could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a rectal prolapse was not a task for an aide to perform.
-She was "nervous" the facility allowed staff to perform these tasks.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was aware that Resident #11 had a history of a rectal prolapse.
-She was not aware that Resident #11 experienced recurring or recent prolapse of the rectum.
-She remembered that Resident #11 would need surgery to correct her rectal prolapse, but this was not recommended

because she would not recover well.
-She did not know staff were correcting Resident #11's rectal prolapse.
-She was concerned staff were managing Resident #11's rectal prolapse and this was a problem.
-She was not aware this was a current problem and staff should have told her.
-She was concerned that staff had not told her Resident #11 was experiencing recurring rectal prolapse.
-She did not train the RCC or any staff on how to manage Resident #11's rectal prolapse.
-Staff should not manage Resident #11's rectal prolapse.
-Resident #11 should be seen by her or be sent out to the hospital.
-She stated she was worried Resident #11 could be prolapsed and needed medical treatment.

The facility failed to ensure 2 of 11 residents received referral and follow up resulting in the Resident Care Coordinator and the medication aides attempting to manage Resident #1's recurring uterine prolapse and Resident #11's recurring rectal prolapse. This failure resulted in substantial risk for serious physical harm constitutes a Type A2 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/2/25 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 7/9/2025.

Rule/Statute Number: 10A NCAC 13F .0909 Resident Rights

Rule/Statutory Reference: 10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

Level of Non-Compliance: Type A2 Violation

Based on the observations, record reviews, and interviews, the facility failed to ensure 2 of 11 sampled residents received appropriate care and services for medical conditions that required management by a health care professional related to

a recurring uterine prolapse (Resident #1) and a recurring rectal prolapse (Resident #11).

Findings:

1. Review of Resident #1's current FL-2 dated 5/30/24 revealed:
-Diagnoses included hypothyroidism, cognitive impairment, left bundle branch block, and gastroesophageal reflux disease (GERD).
-She was ambulatory with the assistance of a walker.
-She was intermittently disoriented.

Review of Resident #1's care note dated 6/18/23 revealed:
-There was documentation at 8:12am the resident was observed with large hard mass out of vagina. Resident was sent out by EMS (emergency medical services) and transported to ER (emergency room) for further evaluation.
- There was documentation at 9:13am the resident was transferred back to the facility with a diagnosis of a "prolapsed uterus".
-To make appointment with obstetrician-gynecologist (OBGYN) for uterine prolapse.

Review of Resident #1's care note dated 6/19/23 revealed a follow up appointment for uterine prolapse was scheduled with an OBGYN on 7/27/23 at 1:45pm.

Interview with a representative from the OBGYN office on 5/2/25 at 9:04am revealed:
-Resident #1 had an appointment scheduled for 7/23/23
-The appointment scheduled for 07/23/23 was cancelled by the facility.
-Resident #1 was not a patient and had not been seen by any provider at the office.

Interview with a personal care aide (PCA) on 4/28/25 at 2:36pm revealed a week ago, Resident #1's uterus prolapsed, and she observed the MA "push" the uterus back into Resident #1's vagina.

Interview with a MA on 4/28/25 at 2:45pm revealed:
-She assisted Resident #1 with her uterine prolapse "about 3 times" each month.
-Resident #1 would let her know when her uterus was prolapsed, and she provided care to correct the issue.
-The Resident Care Coordinator (RCC) showed her how to correct the prolapse sometime around 6/23.
-All MA's were trained by the RCC to push Resident #1's

uterus "back in" when it prolapsed.
-Resident #1 was not sent to the ER or any outside provider for treatment of her prolapsed uterus.
-She informed the RCC whenever she had to push Resident #1's uterus back in, but she did no notify the facility's Nurse Practitioner.

Interview with a second MA on 4/30/25 at 2:10pm revealed:
-She had reinserted Resident #1's prolapsed uterus.
-Resident #1 had notified her when she needed assistance with her uterus.
-Resident #1 had not been sent out for treatment of the prolapsed uterus.
-She did not document when she pushed Resident #1's uterus back in and did not notify the facility's Nurse Practitioner.

Interview with a third MA on 5/1/25 at 11:00am revealed:
-She had pushed Resident #1's uterus back into her vagina two times while being employed at the facility.
-The RCC showed her how to correct the prolapse.
-About a week ago, Resident #1 experienced prolapse. She attempted to push the uterus back in through the vagina, but the uterus would not go back in.
-She called the RCC and the RCC told she would come and get the uterus back in later.
-She did not know how long Resident #1 had to wait for the RCC to come and assist her.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #1's reoccurring uterine prolapse.
-Resident #1's uterus prolapsed "about once a month."
-She trained all the MA's on how to reinsert Resident #1's uterus.
-There was no need to notify the facility's Nurse Practitioner because there was nothing they could do.
-She did not think it was necessary to send Resident #1 to the hospital because she has always been successful with getting the uterus to go back in.

2. Review of Resident #11's current FL-2 dated 7/3/24 revealed:
-Diagnoses included mild dementia, hearing loss, depression, and spinal stenosis.
-She was semi-ambulatory with the assistance of a walker.
-She was intermittently disoriented.
-Incontinence of bowel and bladder.

Review of Resident #1's Care Plan dated 9/2/24 revealed there was no documentation of treatment for reoccurring

rectal prolapse.

Review of Resident #11's care note dated 3/16/23 revealed:
-Resident #11 stated her rectum was out.
-Resident #11's rectum was observed out with blood.
-The RCC instructed to send out.
-Resident #11 returned to the facility with no new orders.

Review of Resident #11's care note dated 10/30/23 revealed:
-Resident #11 complained of rectum falling out.
-Two staff, one of whom was a female aide, went to observe Resident #11.
-Resident #11's rectum was pushed back in.
-The resident was laying and resting.

Review of Resident #11's care note dated 5/7/24 revealed:
-Resident #11 stated her rectum fell out.
-The medication aide (MA) and personal care aide (PCA) pushed rectum back in.

Review of Resident #11's hospital discharge instructions dated 3/16/23 revealed instructions to schedule a follow up appointment with a general surgeon to explore surgical interventions for recurrent rectal prolapse.

Interview with a MA on 4/30/25 at 2:10pm revealed she was trained by another MA and had pushed Resident #11's rectum back in several times.

Interview with second MA on 5/2/25 at 8:45am revealed:
-Resident #11 experienced recurring rectal prolapse for almost two years.
-She corrected the rectal prolapse on "6 separate occasions".
-"The RCC showed her how to push in Resident #11's rectum."

Interview with a PCA on 4/30/25 at 4:25pm revealed:
-About a week ago, Resident #11 came to her saying her bottom burned, and she was not able to have a bowel movement.
-She looked at Resident #11 and her rectum was out about 3 to 4 inches long and it was bright red.
-She informed the MA and "the MA pushed the rectum back in".

Interview with a second PCA on 5/1/25 at 8:48am revealed the MAs corrected the prolapse and she had seen this done about 5-6 times.

Explained to all Medtechs that they are not allowed to perform this procedure due to qualifications not met. Resident must be sent to Jackson Medical Associates or to ER to be evaluated. 6/9/25

Interview with the RCC on 5/1/25 at 9:00am revealed:
-Resident #11 was hospitalized in 2023 for a prolapsed rectum, and treatment would include corrective surgery to prevent future prolapses.
-The surgeon did not recommend surgery because she did not think Resident #11 would be able to recover.
-She "trained" all the MAs on how to reinsert Resident #11's rectum and she learned how to correct prolapses from the facility Nurse Practitioner.
-She did not think it was necessary to send Resident #11 to the hospital because "there was nothing they could do".

Interview with facility Licensed Health Professional Support (LHPS) nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #11 experienced recurring rectal prolapse.
-A rectal prolapse was not a task any aide could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a rectal prolapse was not a task for an aide to perform.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was not aware that Resident #11 experienced recurring or recent prolapse of the rectum.
-She did not know staff were correcting Resident #11's rectal prolapse.
-She was concerned staff were managing Resident #11's rectal prolapse and this was a problem.
-She did not train the RCC or any staff on how to manage Resident #11's rectal prolapse.
-Staff should not manage Resident #11's rectal prolapse.
-Resident #11 should be seen by her or be sent out to the hospital.
-She stated she was worried Resident #11 could be prolapsed and needed medical treatment.

If this happens we must notify facility FNP. So she will instruct us whether FNP is coming to reinsert or if resident is to be sent to JMA or to ER for medical staff to reinsert prolapse uterus or prolapse rectum. 6/16/25

The facility failed to ensure Resident #1 and Resident #11 received adequate and appropriate care and services when the staff did not inform the facility's contracted Nurse Practitioner of recurrence of Resident #1's uterine prolapse and for Resident #11's recurring rectal prolapse. This failure resulted

in substantial risk of serious physical harm will occur and constitutes a Type A2 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/2/25 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 7/9/25.

IV. Delivered Via:	In person	Date: 6/9/25
DSS Signature:	Ali Hamlett, SW III	**Return to DSS By: 6/30/25**

V. CAR Received by:	Administrator/Designee (print name): Cathy Londermilk	
	Signature: Cathy Londermilk RCC	Date: 6/9/25
	Title: RCC	

VI. Plan of Correction Submitted by:	Administrator (print name): Aaron Crawford	
	Signature: A Crawford	Date: 6/30/25 7/9/25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☒ ***POC Accepted***	By: Ali Hamlett, SW III/AHS	Date: 7-10-25
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.*		