Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Ranson Ridge Assisted Living and Memory Care
Address: 4815 North Sharon Amity Rd. Charlotte, NC 28205

County: Mecklenburg

License Number: HAL-060-172

II. Date(s) of Visit(s): 08/30/23, 08/31/23, 09/06/23, 09/07/23, 10/10/23

Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 10/26/23

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 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 *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *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/Resident's Rights Rule/Statutory Reference: 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.	☐ POC Accepted _____ *DSS Initials*	___
Level of Non-Compliance: Type A2 Violation Findings: Based on observations, interviews, and record reviews, the facility failed to protect 1 of 5 sampled residents from further abuse and fear of additional physical harm by allowing a Personal Care Aide (PCA) to continue to work after learning the PCA was accused of hitting the resident with a cell phone in the face (Resident #1). Review of Resident #1's current FL-2 dated 01/19/23 revealed:	Response to the cited deficiencies do not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of correction is prepared solely as a matter of compliance with the law.	

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- Diagnoses included urinary tract infection, hyperlipidemia, esophageal reflux disease, anxiety disorder, and hyperthyroidism. - Resident #1 was semi-ambulatory and used a wheelchair to ambulate. - Resident #1 was intermittently disoriented. - Resident #1 had occasional incontinence of bladder and bowel. - Resident #1 required assisted living level of care.	10A NCAC 13F .0909 Resident Rights The community's management team will assure all residents are free of mental and physical abuse, neglect & exploitation. Business Office Manager & Executive Director will assure compliance.	11/17/23
Review of Resident #1's Admission Record Face Sheet revealed he was admitted to the facility on 09/28/21. Review of Resident #1's most recent Licensed Health Professional Review dated 04/27/23 revealed: - Resident #1 required assistance with transferring and ambulation. - Resident #1 was incontinent of bladder and occasionally bowel. - Resident #1 self-propelled in his wheelchair. Review of Resident #1's Care Plan dated 08/10/23 revealed: - Resident #1 required supervision with eating, limited assistance with toileting, bathing, dressing, grooming, and transferring, and he was able to ambulate independently. - Resident #1 was alert, with confusion. - Resident #1 required the assistance of one person with transferring and toileting. - Resident #1 was incontinent of bladder and occasionally bowel. Telephone Interview with Resident #1's Responsible Party (RP) on 09/06/23 at 3:15pm revealed: - He visited Resident #1 on Sunday afternoon (08/20/23) at about 12:30pm, which was his weekly routine. - Immediately upon seeing Resident #1, he observed an injury on the left side of his face, that appeared to have been a recent injury, including bruising and a cut near his eye, that appeared that it would have bled when it occurred. - It appeared that someone had tended to the wound because there was no dried blood around the cut, but he did not know who may have done so and Resident #1 could not tell him if anyone had cleaned the wound. - He asked Resident #1 what happened to cause the injuries to his face, and he stated an aide "attacked him" with a cell phone the night before after he had pressed his call bell for assistance.	All personnel staff were educated on Declaration of Resident Rights September 23, 2023 by the Executive Director and Regional Vice President of Operations. All personnel staff were educated and completed training on reporting of incidents & accidents November 14, 2023 by the Regional Director of Clinical Services and the Regional Vice President of Operations. State Ombudsman contacted and return email received 11/10/2023 to set up Resident Rights Training & Sensitivity Training with staff and residents. Earliest availability has been scheduled for November 29, 2023. The community will assure that all employees will continue to be educated & receive training regarding resident rights & Incident & Accident Reporting during new hire orientation and routine monthly staff meetings conducted by the Business Office Manager and Executive Director.	9/13/23 11/14/23 11/10/23 11/17/23

- Resident #1 told him he tried to block his face, but it did not help, and the PCA was still able to strike him with the cell phone several times on his face. - After speaking with Resident #1, he went directly to staff to report the assault, and staff said they were not aware Resident #1 had any injuries, and Resident #1 had not reported to any staff that he had been attacked the night before. - On Monday, 08/21/23, he went to the local law enforcement office and filed a police report related to the Resident #1's assault. The officer who took his report stated an officer would go to the facility to investigate the incident. - On Monday 08/21/23, he called the facility to notify them that he had filed a police report, and that an officer would be going to the facility to investigate. - The facility said they would also be calling to make a separate police report. - Resident #1 had not had any falls recently, and there were no other explanations for the injuries to his face. - Resident #1 suffered from Parkinson's Disease and started using a wheelchair all of the time a few months ago. He had a difficult time holding his head up straight. - Resident #1's mind was still sharp. He had never made false accusations about staff or allegations of abuse in the past. Observation of Resident #1 on 08/30/23 at 1:30pm revealed he had bruising across the bridge of his nose and an area of bruising and scabbing about 1 to 1.5 inches long at the corner of his left eye. Interview with Resident #1 on 08/30/23 at 1:30pm revealed: - Resident #1 state he was "attacked" by an aide "a few nights ago." - He had pressed his call bell for assistance because he had an episode of bladder incontinence and needed to be changed. - It took the aide awhile to respond to his call bell. - When the PCA came over to the bed, the PCA held up a cell phone like the PCA was going to hit him, and he told the PCA if she hit him "it would be assault" but it did not stop the PCA from hitting him. - The PCA struck him three times with the cell phone in the face and head. - After hitting him, the PCA proceeded to change his brief. - He did not recall seeing the PCA again that night, but sometime later, possibly the next day, the PCA came back to his room and asked him if he was going to file a report. - Resident #1 told the PCA he was going to file a report, to which she responded "that is going to be a problem."		

- Prior to the night the aide struck him multiple times with a cell phone, he recalled the PCA had provided care to him in the past. - The morning after the assault occurred, his RP visited, and he told him what had occurred the night before. - After the incident occurred, he was afraid to call for assistance for awhile, especially at night. Review of Resident #1's record revealed: - There was no accident report or skin assessment form related to the event that occurred on 08/20/23. - There was no documentation in Resident #1's progress notes regarding the event on 08/20/23, or injuries sustained. Review of local law enforcement Incident Report, dated 08/21/23 at 6:00pm revealed: - The report documented on 08/21/23 at 4:00am, Resident #1 was assaulted, and sustained bruises and scratches. The report did not document the location of the injuries sustained to Resident #1 or any other information about the assault. - An "outside family" member of Resident #1 made the report of assault to law enforcement. - The offense classification was documented as Assault: Simple or Aggravated on Handicapped Person. Interview with local law enforcement public record division on 09/08/23 at 11:31am revealed there was only one police report filed for the facility's address during the last 3 weeks. Interview with facility weekend nurse on 08/31/23 at 11:05am and 09/07/23 at 11:25am revealed: - Resident #1's RP approached her on 08/20/23 around 12:30pm and informed her that Resident #1 had injuries to his face and that he wanted an investigation completed to determine what had occurred. - She and the RP went to Resident #1's room together, and she assessed his injuries, which included bruises and scratches. - She asked Resident #1 what had happened, and he reported that a staff member attacked him with a cell phone the night before and took his call bell away from him. - Resident #1 was not able to tell her who the staff member was that had assaulted him. - She looked at the facility assignment sheet for the previous night and identified which staff member was assigned to Resident #1. - She could not recall if the staff member who was assigned to Resident #1 the night of the incident worked the next day, when she became aware of the incident.		

- After speaking with Resident #1, she called the Resident Care Director (RCD) and reported the incident and told him who the staff was that was assigned to Resident #1 when the alleged assault occurred. - The RCD directed her to complete an incident report and write a statement of what had been reported to her. - She completed the incident report and wrote a statement of what had been reported to her and left it for the RCD. - She did not keep a copy of the incident report or her written statement. - No management staff, including the Administrator or the RCD came to the facility while she was there on 08/20/23 to conduct an investigation. - She recalled seeing the injuries to Resident #1's face earlier in the day on 08/20/23, but she had not asked him directly what had occurred to cause the injuries. - She looked back through recent documentation to see if Resident #1 had a recent fall that might have caused the injuries but did not see any documentation. - Three other staff reported to her on 08/20/23 that Resident #1 had injuries and had reported to them that he was assaulted the night before and "snatched his call bell" but she was unsure if they reported the allegation to her before or after Resident #1's RP notified her of Resident #1's injuries. Interview with a PCA on 09/07/23 11:20am revealed: - She worked on Sunday (8/20/23) on 1st shift and was assigned to provide care to Resident #1. - Before lunchtime, she noticed he had an injury to the left side of his forehead near the corner of his eye. - She did not recall if it was just a bruise or if there was dried blood, but recalled the resident said it did not hurt. - She asked Resident #1 what happened, and he said there was a "dangerous person working last night" and that the dangerous person had hit him with a cell phone. - Resident #1 was not able to tell her who the staff member was that had hit him. - She asked him if the staff member had accidentally dropped a cell phone on him and he stated it was not an accident, and the dangerous person had hit him several times. - She asked another staff member who had worked at the facility longer than her if Resident #1 was ever confused or falsely accused people of hurting him, and the other staff member stated he was not a confused resident, and that he could accurately remember events. - She immediately notified the weekend nurse who was working in the building at the time, and the nurse went to Resident #1's room to assess his injuries.		

- She had observed the injury and reported it to the weekend nurse prior to Resident #1's RP arriving to visit. Interview with a Medication Aide (MA) on 09/07/23 at 2:00pm revealed: - She worked on Sunday (08/20/23) and recalled she did not notice any injury on Resident #1's face earlier in the day when she took him his medications in his room, because of the way he kept his head turned all the time, and also because he kept it dark in his room because he had light sensitivity. - Resident #1 did not tell her that he had been attacked the night before, but she heard from other staff on the shift that he had reported this to them. - She worked during the day on 08/19/23, and recalled he was not acting out of the ordinary that day. - On Sunday (08/20/23), after she observed the injury later in her shift, she realized he had been quieter than usual and he had not called for assistance as often as he normally would, and that he "seemed sad." - Resident #1 did not have dementia and was not a confused resident. - Resident #1 had never made any other allegations of abuse against staff. - Resident #1 had not had any recent falls and self-ambulated in his wheelchair. Interview with the Resident Care Director on 09/06/23 at 10:20am and 09/07/23 at 12:05pm revealed: - The weekend nurse notified him of an allegation of abuse on Sunday (8/20/23) between 2:00 and 3:00pm. - The weekend nurse told him Resident #1 reported to her that a staff member hit him in the face the night before with a cell phone. - He directed the weekend nurse to get a statement from Resident #1 and to complete an incident report. - He did not go to the facility on 08/20/23. - He could not recall if he notified the Administrator of the allegation on 08/20/23, or if they discussed the following day, on Monday (08/21/23), for the first time. - He recalled he looked at the facility assignment list from the previous night to see who had been assigned to Resident #1. - At the time, he did not feel like he had enough information to suspend the staff member until he had completed an investigation. - He did not know if the accused staff member had worked later in the day on 08/20/23.		

- On Monday morning (08/21/23), he interviewed Resident #1 regarding the alleged assault, and Resident #1 reported the same event that he had told the weekend nurse the day before.
- After interviewing the resident, he discussed the incident with the Administrator, and they determined the accused staff needed to be suspended until the investigation was complete.
- The accused staff reported to the facility to work her scheduled shift, on 08/21/23 at 3pm, and they informed her that she was being suspended, pending an investigation related to an allegation of abuse, and she was directed to immediately leave the premises.
- When the accused staff member left the office, they watched on the live video footage that she did not go out the front door, but instead started down the hall on which Resident #1 resided.
- He and the Administrator quickly went to Resident #1's room and observed the accused staff member standing over Resident #1 in his wheelchair, looking at his forehead.
- He directed the PCA to immediately exit the room.
- After the PCA exited the room, he asked Resident #1 if he recognized the staff member that had just been in his room, and he stated "yes, she is the one who hit me with a cell phone."
- Resident #1 stated the PCA hit him because he was yelling out for help and could not find his call button the night of the incident.
- The Administrator was responsible for completing any investigations related to allegations of abuse, and he assisted with the investigations as directed.
- He was unsure when law enforcement was contacted by the facility related to the incident.
- He thought Resident #1's physician was contacted related to the incident but was not certain.
- He was unable to locate the incident report that the weekend nurse completed when he became aware of the incident.

Review of the facility assignment sheets revealed the accused staff member was assigned to Resident #1 on third shift the night of 08/19/23, and early hours of 08/20/23.

Review of facility time punch documentation revealed the accused staff member worked on 08/20/23 from 2:58pm – 11:22pm.

Review of facility assignment sheets on 08/20/23 revealed the accused staff member worked second shift and was assigned to another hallway where Resident #1 did not reside.

Interview with Administrator on 08/30/23 at 1:00pm revealed:

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- She reported a staff member to the Healthcare Registry (HCPR) on 08/21/23, for an allegation of abuse. - She did not report the allegation of abuse to the Department of Social Services because her Regional Director told her this was not required. - The facility became aware of the allegation of abuse on Sunday (08/20/23), and conducted an investigation on 08/21/23, and sent the report to the HCPR on 08/21/23. - Resident #1 reported a PCA struck him in the head twice with a cell phone on 08/20/23, around 4:00am. - The resident sustained a cut and bruising at the corner of his eye and bruising across the bridge of his nose. - On Monday (08/21/23), after the RCD completed an interview with the resident and with other staff members, she called the accused PCA to the building, and informed the PCA she was suspended, pending an investigation of abuse, and directed her to immediately leave the facility. - The accused PCA left her office, and she observed on video that she was heading down the hallway on which Resident #1 resided. - She and the RCD immediately went to the resident's room, and stopped the accused PCA before she went into his room. - She received other complaints from staff and residents about the accused staff member having a "bad attitude" when doing a task, she did not want to do, but there had never been any allegations of physical abuse and it did not sound like it had ever crossed the line to abuse. Interview with the Regional Director of Clinical Services (RDCS) on 09/07/23 at 2:00pm revealed: - She received a message from the RCD around 4:00pm on 08/20/23, that he needed to speak with her. - She was in a facility at the time she received the message and did not speak with him until about 7:00pm on 08/20/23, when he informed her there had been an allegation of abuse made by a resident. - She asked him if the Administrator had notified the Regional Vice President of Operations (RVPO) yet, and he said he was not sure. - She directed him to tell the Administrator she needed to report the allegation to the RVPO immediately. - At the time she spoke with the RCD, he did not know which staff member may have been involved in the incident, because no investigation had begun at that time. Interview with the RVPO on 09/07/23 at 2:00pm revealed:		

- She was on site today at the facility to conduct an investigation, related to how the allegation of abuse for Resident #1 was handled by the facility's Administrator. - She was not informed of the allegation of abuse until Sunday evening (08/20/23), after the RCD had notified the RDCS of the allegation, and the RDCS had reached out to her to see if she had been notified by the Administrator of an allegation. - The Administrator called her soon after she spoke to the RDCS, around 7:00pm on Sunday evening (08/20/23) to inform her that there was an allegation of abuse made by a resident, and that the resident had some redness around his eye as a result of the incident. - The Administrator told her that she had been busy and had forgotten to report the allegation to her earlier in the day. - The Administrator did not follow company policy related to investigating allegations of abuse. - The company policy documented that the Administrator or RCD was supposed to immediately go to the building, upon any allegations of abuse being made, and begin an investigation by interviewing all staff that were present. - Law enforcement and the Department of Social Services should have been notified by the facility immediately, upon learning of the allegation of abuse. - She was not sure at what point, or if, law enforcement had been contacted by the facility. - The Administrator should have immediately notified her, the RVPO, of any allegations of abuse, per the company policy. - The accused PCA should have immediately been suspended on 08/20/23, when the allegation was made, and under no circumstances should have been allowed to work in the facility until the investigation was completed. - She became aware the accused staff worked on Sunday, after the incident occurred, during her investigation. - The Administrator was currently suspended, pending the outcome of the investigation. The facility failed to protect Resident #1 and all other residents from physical abuse by allowing a PCA to continue to work the next day after being accused of hitting Resident #1 multiple times in the head and face. This failure resulted in Resident #1 being reluctant to request for assistance and placed all of the residents at a substantial risk for physical harm and constitutes a Type A2 Violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 11/25/23.		

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The facility provided a Plan of Protection on 09/07/23 in accordance with G.S. 131-34.		
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.	☐ POC Accepted _____ *DSS Initials*	____
Level of Non-Compliance: Citation Findings: Based on record reviews and interviews, the facility failed to notify the a.) department of social services and b.) local law enforcement upon becoming aware of an alleged incident of abuse of a resident (Resident #1) by a Personal Care Assistant (PCA). Review of facility's 15-page North Carolina Resident Abuse Policy, effective May 2008 revealed: - The facility would contact the police when the facility received a complaint of, or suspected sexual abuse, serious bodily injury, or suspicious death. - If appropriate the social services department should be notified of the incident so that they may take appropriate interventions to care for the psychosocial needs of any involved residents. Review of Resident #1's current FL-2 dated 01/19/23 revealed: - Diagnoses included urinary tract infection, hyperlipidemia, esophageal reflux disease, anxiety disorder, and hyperthyroidism. - Resident #1 was semi-ambulatory and used a wheelchair to ambulate. - Resident #1 was intermittently disoriented. - Resident #1 had occasional incontinence of bladder and bowel. - Resident #1 required assisted living level of care. Review of Resident #1's Admission Record Face Sheet revealed he was admitted to the facility on 09/28/21.	Response to the cited deficiencies do not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with the law. 10A NCAC 13F .1212(d) Reporting of Accidents & Incidents. Personnel Staff educated and received training on reporting of incident and accidents. Staff will report to the SIC/MT and they will then report to the RCD, RCD will inform the ED and the ED to the RVPO. The community will assure that all personnel staff will receive education & training on Reporting of Incident & Accident during new hire orientation and routine staff meetings. Business Office Manager & Executive Director will monitor for compliance.	11/17/23 11/17/23

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Telephone Interview with Resident #1's Responsible Party (RP) on 09/06/23 at 3:15pm revealed: - He visited Resident #1 on Sunday afternoon (08/20/23) at about 12:30pm, which was his weekly routine. - Immediately upon seeing Resident #1, he observed an injury on the left side of his face, that appeared to be a recent injury, including bruising and a cut near his eye, that appeared that it had bled when it occurred. - He asked Resident #1 what happened to cause the injuries to his face, and he stated a PCA "attacked him" with a cell phone the night before after he had pressed his call bell for assistance. - After speaking with Resident #1, he went directly to staff to report the assault, and staff said they were unaware Resident #1 had any injuries, and Resident #1 had not reported to any staff that he had been attacked the night before. - On Monday, 08/21/23, he went to the local law enforcement office and filed a police report related to the Resident #1's assault. The officer who took his report stated an officer would go to the facility to investigate the incident. - On Monday 08/21/23, he called the facility to notify them that he had filed a police report, and that an officer would be going to the facility to investigate. - The facility said they would also be calling to make a separate police report. a.) Review of facility documentation revealed the facility could not produce any documentation that they had notified the local Department of Social Services of the allegation of abuse on 08/20/23. Interview with Administrator on 08/30/23 at 1:00pm revealed: - She reported a staff member to the Healthcare Registry (HCPR) on 08/21/23, for an allegation of abuse. - She did not report the allegation of abuse to the Department of Social Services because her Regional Director told her this was not required. - The facility became aware of the allegation of abuse on Sunday (08/20/23), and conducted an investigation on 08/21/23, and sent the report to the HCPR on 08/21/23. - Resident #1 reported a PCA struck him in the head twice with a cell phone on 08/20/23, around 4:00am. - The resident sustained a cut and bruising at the corner of his eye and bruising across the bridge of his nose. Interview with the Regional Vice President of Operations (RVPO) on 09/07/23 at 2:00pm revealed:	The Executive Director and Resident Care Director received education and training on proper procedures for completing HCPR Complaint Intake and correct procedure for conducting Investigation & Reporting to local law enforcement of any allegation of abuse & neglect by the Regional Director of Clinical Services & the Regional Vice President of Operations. Skin Observations were completed on all residents by the Resident Care Director. Any concerns that would be identified will be sent to PCP for further advise. No further findings were identified. All MT/SIC were educated on completion of Incident & Accident Reports, Skin Observations and documentation by the Resident Care Director. Personnel Staff educated and received training on reporting of incidents & accidents and Resident Rights by the Resident Care Director & Executive Director. The community will assure all employees will continue to be educated regarding resident rights and Reporting Of Incidents & Accidents during new hire training and routine staff meetings. Business Office Manager and Executive Director will monitor for compliance	9/6/23 9/15/23 11/14/23 11/14/23 11/17/23

- She was on site today (09/07/23) at the facility to conduct an investigation, related to how the allegation of abuse for Resident #1 was handled by the facility's Administrator. - The Administrator did not follow company policy related to investigating allegations of abuse. - The company policy documented that the Administrator or Resident Care Director (RCD) was supposed to immediately go to the building, upon any allegations of abuse being made, and begin an investigation by interviewing all staff that were present. - Law enforcement and the Department of Social Services should have been notified by the facility immediately, upon learning of the allegation of abuse. - The Administrator was currently suspended, pending the outcome of the investigation. b.) Review of facility documentation revealed they could not produce any documentation that they had notified local law enforcement of the allegation of abuse on 08/20/23. Review of local law enforcement Incident Report, dated 08/21/23 at 6:00pm revealed: - The report documented on 08/21/23 at 4:00am, Resident #1 was assaulted, and sustained bruises and scratches. The report did not document the location of the injuries sustained by Resident #1 or any other information about the assault. - An "outside family" member of Resident #1 made the report of assault to law enforcement. - The offense classification was documented as Assault: Simple or Aggravated on Handicapped Person. Interview with local law enforcement public record division on 09/08/23 at 11:31am revealed there was only one police report filed for the facility's address during the last 3 weeks. Interview with the Resident Care Director on 09/06/23 at 10:20am and 09/07/23 at 12:05pm revealed: - The Administrator was responsible for completing any investigations related to allegations of abuse, and he assisted with the investigations as directed. - He was unsure when law enforcement was contacted by the facility related to the incident. Interview with the RVPO on 09/07/23 at 2:00pm revealed: - The Administrator did not follow company policy related to investigating allegations of abuse. - The company policy documented that the Administrator or RCD was supposed to immediately go to the building, upon	Personnel Staff educated on the Declaration of Resident Rights September 23, 2023 by the Executive Director and Regional Vice President of Operations. All personnel Staff were educated and completed training on Reporting of incident & accidents November 14, 2023 by the Regional Director of Clinical Services & Regional Vice President of Operations. State Ombudsman contacted and return email received 11/10/2023 to set up Resident Rights & Sensitivity Training with staff and residents. Earliest availability has been scheduled for November 29, 2023.	9/23/23 11/14/23 11/10/23

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any allegations of abuse being made, and begin an investigation by interviewing all staff that were present. - Law enforcement and the Department of Social Services should have been notified by the facility immediately, upon learning of the allegation of abuse. - She was not sure at what point, or if, law enforcement had been contacted by the facility. - The Administrator was currently suspended, pending the outcome of the investigation.		

IV. Delivered Via:	Certified mail and hand delivery	Date: 10/26/23
DSS Signature:	Denise Boudeman	Return to DSS By: 11/17/23

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

VI. Plan of Correction Submitted by:	Administrator (print name): Debra Richardson	
	Signature: Amy H. Ricks, ROCS for Debra Richardson	Date: 11/17/2023

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted*	By:	Date:
Comments:		
☒ *POC Accepted*	By: Denise Boudeman	Date: 11/21/23
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.*