Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Enclave @ Pinedale
Address: 4613 Pinedale Drive Durham, NC 27705
II. Date(s) of Visit(s): 01/16/25, 01/20/25, 01/23/25

County: Durham County
License Number: FCL-032-184
Purpose of Visit(s): Complaint Investigation NC00226106
Exit/Report Date: 02/13/2025

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)* • *Rule/Statutory Reference (text of the rule/statute 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 13G. 0902 Health Care	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: 10A NCAC 13G. 0902 Health Care (a) A family care home shall provide care and services in accordance with the residents' care plan. (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. (c) The facility shall assure documentation of the following in the residents' record: (1) facility contacts with the residents' physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care.		
Level of Non-Compliance: A1 VIOLATION		
Findings: The rule is not met as evidenced by:		

Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) who eloped from the home and fell outside, was sent to the hospital for evaluation in a timely manner, and the primary care provider was notified when the resident complained of pain.

The findings are:

Review of the facility's undated Steps for Wandering Residents revealed:
-Establish resident wandered off.
-Thoroughly search the inside/outside premises of the community for no more than 15 minutes.
-Contact the Administrator immediately, dial 911 immediately if needed
-Contact department of social services and responsible party of the resident's disappearance.

Review of the facility's undated Resident Falls policy on revealed:
-All residents falls will be recorded on an incident form.
-The supervisor will contact the Resident Coordinator.
-The Resident Coordinator will contact the doctor and based on the doctor's recommendation, the resident is either monitored or sent to the hospital.

Review of Resident #1's hospital FL-2 dated 11/05/24 revealed:
-Diagnoses included fall with rib fracture and hip fracture on 9/29/24.
-Resident #1 was intermittently disoriented.
-Resident #1 was non-ambulatory.

Review of Resident #1's previous FL-2 dated 06/04/24 revealed:
-Diagnosis included encephalopathy, hypoglycemia, acute sacral fracture, urinary retention, coronary artery disease, chronic macrocytic anemia, benign prostatic hyperplasia, and chronic constipation.
-Resident #1 was intermittently disoriented.
-Resident #1 was ambulatory with walker.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 05/07/24 revealed:
-Primary diagnosis was dementia.
-Resident #1 was weak and unsteady.
-Resident #1 would need to be assisted every day.
-Monitor Resident #1's mood, food intake and gait.

Review of Resident #1's Care Plan dated 03/27/24 revealed:
-Resident #1 needed limited assistance with ambulation/locomotion.
-Resident #1 needed limited assistance with transferring.
-Resident #1 used a wheelchair.

Review of the incident report for Resident #1 dated 01/10/25 at 1:50am revealed:
-Staff went to the bathroom; Resident #1 walked out the facility and fell on gravel. Vitals were taken immediately. Notified the Resident Care Coordinator (RCC).
-Resident #1 had no visible injuries at this time.
-Resident #1 was very confused and had been trying to go deliver mail since 10:30pm.

Review of the Emergency Medical Services (EMS) records dated 01/10/25 revealed:
-The EMS call was received at 3:23pm on 01/10/25.
-The EMS call was dispatched at 3:26pm on 01/10/25.
-EMS was on scene at 3:40pm on 01/10/25.
-EMS transported Resident #1 to the hospital at 4:17pm on 01/10/25.
-Staff reported Resident #1 was unable or unwilling to move his right arm and leg and he complained of pain.
-Staff reported that there was no record of a fall or any trauma.
-Resident #1 had pain in the right side, both arms and legs, as well as his neck and back.
-Resident #1 had a large bruise on his right upper arm and shoulder with significant swelling present and tenderness to palpation of the right hip and upper leg.

Review of Resident #1's hospital discharge summary dated 01/13/25 revealed:
-He was admitted to the hospital on 01/10/25.
-Admission diagnoses were trauma, encephalopathy, and hematoma of the right shoulder.
-Surgeries performed for Resident #1 included treatment of femoral fracture.
-Resident #1 was discharged to inpatient hospice on 01/13/25 for comfort/directed care.
-Resident #1was declining progressively and unable to consume orally.
-Resident #1 expired on 01/14/25 at 1:57am in inpatient hospice care.

Interview with the neighbor on 01/16/25 at 12:50pm revealed:
-She was watching TV around 1:30am on 01/10/25.

-She heard whining sounds for 10 to 15 minutes outside and she thought it was cats.
-She went outside to her car port and heard a cry for help.
-She saw a figure at the red door of the facility lying on their back and their arm was under their back.
-The person was awake and alert.
-She went onto the covered porch and banged on the door that entered the facility, but no one answered.
-She went to the front door of the facility, which was unlocked and opened, and she called out for help.
-She walked inside the facility and into the hallway calling for help.
-A female came out of the back room.
-She told the female that there was a person outside.
-She helped the female get the person up from the ground.

Interview with an Supervisor in Charge (SIC) on 01/16/25 at 7:39pm revealed:
-She came into work on 01/09/25 at 10:00pm and worked until 01/10/25 at 6:00am.
-Resident #1 started walking down the hall at 10:30pm saying he wanted to deliver the mail.
-She had to keep redirecting the resident to his room.
-After 1:00am, she went into his bedroom to sit with him.
-He was lying in the bed with his eyes open.
-She went into Resident #1's bathroom for 30 minutes having a bowel movement.
-She heard a noise inside the house around 1:50am and a lady saying that there was someone outside.
-She followed the lady to the side of the facility and saw Resident #1 on the ground in front of a red door.
-Resident #1 was lying on his back.
-Resident #1 was alert and said that he was in pain.
-The neighbor helped her pick up Resident #1 and she brought him back into his room.
-She took Resident #1's vitals and called the RCC.
-The RCC told her to monitor Resident #1 by watching him and take vitals if needed.
-She completed the incident report.
-She was trained to call the RCC for any emergencies.
-She did not take off Resident #1's clothes to see if he had injuries.
-Resident #1 said his arm and leg were hurting.
-She did not give Resident #1 any medication and she did not call the Power of Attorney (POA) because she was not told to.
-Resident #1 went to sleep 35 minutes later.
-The Administrator came to the facility at 6:00am and she explained to him what happened.

-Resident #1 did not have a bed alarm or chair alarm.
-She completed an incident report but did not call EMS or the POA when Resident #1 fell.
-The RCC would call the POA or Primary Care Provider (PCP) to let them know of incidents.
-She was not aware of any fall preventions in place for Resident #1.

Interview with the Administrator on 01/16/25 at 1:06pm revealed:
-He came into the facility to work on 01/10/25 from 7:00am to 2:00pm.
-He observed Resident #1 in his bed yelling in pain when lifting his shoulder and leg.
-He was told by the (SIC) that she was in the bathroom around 1:30-1:40am and Resident #1 walked out the front door and he fell outside.
-He did not know specifically what happened to Resident #1.
-The RCC called the (PCP) and the (POA).
-Resident #1 was complaining of pain in his right shoulder and right leg.
-He did not think Resident #1's injuries were bad enough to call EMS because Resident #1 always complained that he was in pain.
-The RCC called EMS at 3:30pm on 01/10/25.
-It was the RCC's responsibility to call the PCP and notify Department of Social Services when a resident had an accident.

Interview with another SIC on 01/16/25 at 3:34pm revealed:
-She heard three different stories of what happened to Resident #1.
-She came into work on 01/10/25 at 2:00pm and the Administrator left when she got there.
-The Administrator said he was waiting on the PCP to come and see Resident #1.
-Resident #1 was lying in his bed with no blanket on and with just a pull up on.
-No one told her what happened to Resident #1.
-Resident #1 said his right leg hurt.
-She did not observe bruising or swelling.
-The RCC told her that Resident #1 had not drank or eaten food.
-She was told by the SIC who was working at the time of the incident that she was in the bathroom when Resident #1 walked out of the home.
-A neighbor found him outside.
-Resident #1 had never fallen on her shift.

-The Administrator and RCC should have called EMS sooner.
-Resident #1 left to go to the hospital at 6:00pm or 7:00pm after the RCC called EMS.

Interview with the RCC on 01/20/25 at 11:00am revealed:
-She received a call from the SIC around 2:00am on 01/10/25.
-She did not remember a conversation about elopement due to being woken up from sleep.
-The Administrator called her at 8:00am on 01/10/25 and told her that Resident #1 fell.
-She called the POA and told him that Resident #1 fell.
-At that time, she did not know how Resident #1 fell.
-She called the PCP and left a message and emailed them about obtaining an X-Ray for Resident #1 after 8:00am.
-She came to the facility at 3:00pm on 01/10/25.
-Resident #1 was in bed awake with a shirt on and no pants.
-Resident #1's arm looked swollen and red, and she did not see anything wrong with his leg.
-Resident #1 said his shoulder and legs hurt.
-She called EMS around 3:00pm and told them that he had fallen.
-She did not call EMS right away because she called the POA to figure out what he wanted her to do.
-She did not read the incident report until after EMS left with Resident #1.
-She was not aware of Resident #1's elopement until she read the incident report.

Interview with Resident #1's PCP on 01/21/25 at 3:51pm revealed:
-She received an email from the facility RCC at 11:00am requesting an X-Ray for Resident #1.
-The office received a voicemail from the RCC at 11:07am stating that Resident #1 fell between the bed and the wall.
-She saw the RCC after 3:00pm at another facility and she was informed that Resident #1 had arm pain, and she was asked about an X-Ray or to send Resident #1 to the hospital.
-She told the RCC to send Resident #1 to the hospital.
-The facility should fax or call their office immediately if a resident fell.

Interview with the Paramedic with EMS on 01/24/25 at 3:00pm revealed:
-Resident #1 was lying in bed, he was dressed, confused, and alert when he arrived at the facility on 01/10/25.
-Resident #1 did not have right arm movement but he had tenderness to the right arm, bruising of the right arm, and a swollen right shoulder.

-There was no assessment of Resident #1's legs.
-He observed two women working in the facility.
-He was told by an unknown named staff that Resident #1 was not able to get dressed and he could not move his arm.
-He asked multiple times if Resident #1 fell, and the staff denied any falls.
-The staff told him that Resident #1 was in bed all night.
-The staff told him that they did not know how he got hurt and kept denying trauma.
-The staff acted like they did not know about the bruises on Resident #1's arm.

Interview with a representative from Resident #1's PCP office on 01/28/25 at 2:55pm revealed; their office was told that Resident #1 was found awake in an awkward position in the bed on 01/10/25 and they requested an X-Ray.

Review of Resident #1's death certificate dated 01/20/25 revealed:
-Date of injury was 01/10/25.
-Immediate cause of death was blunt force injury to the right leg.
-Manner of death was an accident and injury occurred by fall at assisted living facility.

The facility failed to notify the primary care provider when a resident (#1) fell and was found outside of the facility by a neighbor. The resident complained of pain to his right arm, leg, back and neck, and was noted to have bruising on his right arm and swelling to his right hip and leg, and the facility did not send the resident for evaluation at the local hospital until over 12 hours had passed since he was found outside. The resident passed away from complications related to his hip fracture. This failure resulted in neglect and serious physical harm and pain, which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/23/25 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 03/14/25.

Rule/Statute Number:
10A NCAC 13G. 0901 Personal Care and Supervision

☐ POC Accepted

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DSS Initials

Rule/Statutory Reference:

10A NCAC 13G. 0901 Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.
(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

Level of Non-Compliance:

A1 VIOLATION

Findings:

The rule is not met as evidence by:

Based on observations, interviews and records reviews, the facility failed to ensure supervision according to the resident's assessed needs for 1 of 3 sampled residents (#1), who eloped from the facility and was found by a neighbor, resulting in a right hip and right humerus fracture.

The findings are:

Review of the facility's undated policy on Identification and Supervision of Wandering Residents revealed:
-If a resident displays wandering behavior that poses a threat to their safety and current measures do not solve this issue, the resident's physician will be contacted for reassessment and treatment if deemed warranted to correct the behavior.
-If the resident's wandering behavior cannot be addressed with bed checks, the community may increase the resident's supervision or issue an appropriate discharge as permitted by the rules to a higher level of care to ensure their safety when wandering.
-Regular checks of residents who are at risk of wandering.
-Keep the provided door alarm systems always tested and on.
-Keeping the wandering residents in the view of staff as often as possible.

Review of Resident #1's hospital FL-2 dated 11/05/24 revealed:
-Diagnoses included fall with rib fracture and hip fracture on 9/29/24.
-Resident #1 was intermittently disoriented.
-Resident #1 was non-ambulatory.

Review of Resident #1's previous FL-2 dated 06/04/24 revealed:
-Diagnosis included encephalopathy, hypoglycemia, acute sacral fracture, urinary retention, coronary artery disease,

chronic macrocytic anemia, benign prostatic hyperplasia, and chronic constipation.
-Resident #1 was intermittently disoriented.
-Resident #1 was ambulatory with walker.

Review of Resident #1's Care Plan dated 03/27/24 revealed:
-Resident #1 needed limited assistance with ambulation/locomotion.
-Resident #1 needed limited assistance with transferring.
-Resident #1 used a wheelchair.

Review of the outside temperature on 01/10/25 around 1:30am revealed; temperature high 37 degrees and low 23 degrees.

Observation of the facility on 01/16/25 at 11:40am revealed; there was a camera in the hallway, at the entrance of the front door and at the back door.

Observation of the facility 01/16/25 at 11:45am revealed:
-There was ice on the ramp leading to the front door of the facility.
-Only one doorbell rang when the front and back door opened.
-Resident #1's chair and bed alarm could not be located.

Interview with Resident #1's Power of Attorney (POA) on 01/15/25 at 12:00pm revealed:
-He was told by a Supervisor in Charge (SIC) when he picked up Resident #1's things on 01/13/25 that the staff on duty was using the bathroom while Resident #1 got outside without hearing the alarm and a neighbor found him outside.
-Resident #1's arms were bruised, his right hip was broken, and his right shoulder was fractured.
-The cause of death was an accident due to the hip fracture from the fall.
-The staff allowed Resident #1 to go to the bathroom by himself.
-He did not know how Resident #1 was able to walk outside by himself because he needed assistance with a walker or wheelchair.
-The Administrator and Resident Care Coordinator (RCC) told him that they would find out what happened and would get back with him, but they did not say that he fell outside.

Interview with a SIC on 01/16/25 at 11:33am revealed:
-She was trained to fill out an incident report and place it in a binder.
-She was trained to call the RCC to get directions on what to do next.

-She was not trained to call the POA, Department of Social Services, or the primary care provider (PCP) when an accident happened.
-She was told that the SIC on duty on 01/10/25, was in the bathroom while Resident #1 fell, and she did not know how he fell.
-The cameras worked on the outside and in the hallways of the home.
-Resident #1 never went outside on her shifts.
-Resident #1 never had an alarm on his bed or chair.
-She requested floor mats for Resident #1 when he fell in the past.
-Resident #1 needed help with standing, but he could transfer on his own; he could not take steps without his walker.

Interview with the neighbor on 01/16/25 at 12:50pm revealed:
-She was watching TV around 1:30am on 01/10/25.
-She heard whining sounds for 10 to 15 minutes outside and she thought it was cats.
-She went outside to her car port and heard a cry for help.
-She saw a figure at the red door of the facility lying on their back and their arm was under their back.
-The person was awake and alert.
-She went onto the covered porch and banged on the door that entered the facility, but no one answered.
-She went to the front door of the facility, which was unlocked and opened, and she called out for help.
-She walked inside the facility and into the hallway calling for help.
-A female came out of the back room.
-She told the female that there was a person outside.
-She helped the female get the person up from the ground.

Interview with Administrator on 01/16/25 at 1:06pm revealed:
-The SIC on duty told him that Resident #1 was up a lot that night and getting out of bed on 01/10/25.
-The SIC on duty on 01/10/25 was in his room because he kept on getting up.
-The SIC on duty on 01/10/25 was in the bathroom while Resident #1 walked out the front door.
-The alarms on the doors were working.
-The cameras on the outside and inside of the facility only recorded for 3 hours and erase.
-He and the RCC did not look at the camera footage from 01/10/25 when Resident #1 eloped.
-He had not talked to the neighbor to see what happened.
-Resident #1 had an alarm on his bed, an alarm on his chair, an emergency necklace, and a floor mat.

-He wanted the staff to help Resident #1 with transfers, walking, bathes, and putting on his clothes.
-Resident #1 never attempted to wander out of the facility during his shifts.
-Resident #1 talked about leaving but had never attempted to wander outside.
-He did not allow staff to sleep on their shifts.
-They did not have a policy on staff not sleeping during their shift.
-The doors locked on the outside but not the inside of the facility.

Interview with another SIC on 01/16/25 at 3:34pm revealed:
- She was told by the SIC who was working on 01/10/25 at the time of the incident that the SIC was in the bathroom when Resident #1 walked out of the facility.
-A neighbor found him outside.
-Resident #1 did not have a bed or floor mat.
-Resident #1 never wandered or tried to leave the facility.
-Resident #1 said his right leg hurt.
-She did not observe any bruising or swelling on his legs or arms.
-There was ice on the ramp when she came into work on 01/10/25.
-Resident #1 could not walk on his own and needed assistance.

Interview with a third SIC on 01/16/25 at 5:55pm revealed:
-Resident #1 could get up, but he could not walk by himself.
-Resident #1 could roll himself around in his wheelchair.

Interview with a fourth SIC on 01/16/25 at 7:39pm revealed:
-She worked third shift from 10:00pm on 01/09/25 to 6:00am, 01/10/25.
-She was in the bathroom for 30 minutes on 01/10/25 after 1:00a.m having a bowel movement and Resident #1 was in his bed awake.
-She did not hear the alarm go off at the front door, but it was working.
-Resident #1 was always confused at night.
-Resident #1 did not need assistance to walk.
-Resident #1 had never wandered out of the home before.

Interview with the RCC on 01/20/25 at 11:00am revealed:
-Resident #1 did not wander and he could get up by himself.
-She had worked third shift in the past and Resident #1 never got out of his bed.
-Resident #1 would say he was going somewhere but would never attempt it.

Interview with Resident #1's PCP on 01/21/25 at 3:51pm revealed:
-She received an email from the RCC at 11:00am requesting an X-Ray for Resident #1.
-The office received a voicemail from the RCC at 11:07am stating that Resident #1 fell between the bed and the wall.
-She saw the RCC after 3:00pm at another facility and she was informed that Resident #1 had arm pain, and she was asked about an X-Ray or to send Resident #1 to the hospital.
-She told the RCC to send Resident #1 to the hospital.
-The facility should fax or call their office immediately if a resident fell.

The facility failed to provide supervision to a resident (#1), who had a diagnosis of dementia, was intermittently disoriented, and eloped from the facility and was found outside on the ground by a neighbor. The staff was reportedly in the bathroom for approximately 30 minutes when the resident wandered from the facility, fell, and sustained fractures to his hip and shoulder. The resident was transported to the local hospital over twelve hours after the fall, where he passed away from complications related to a hip fracture. This failure resulted in neglect and serious physical harm, which constitutes Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D -34 on 01/16/25 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 03/14/25.

Rule/Statute Number:
10A NCAC 13G. 1213 Reporting of Accidents and Incidents

☐ POC Accepted

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DSS Initials

Rule/Statutory Reference:
10A NCAC 13G. 1213 Reporting of Accidents and Incidents
(a) A family care home shall notify the county department of social services of any accident or incident resulting in a resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.

Level of Non-Compliance:

Standard Deficiency

Findings:

The rule is not met as evidence by:

Based on interviews and record reviews, the facility failed to notify the Department of Social Services of all accidents and incidents for 2 of 3 sampled residents (#1, #2) who had falls.

The findings are:

Review of facility's undated policy for Reporting of Accidents and Incidents revealed; the Administrator would notify the county Department of Social Service (DSS) of any accident or incident resulting in resident death or any serious accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.

1. Review of Resident #1's hospital FL-2 dated 11/05/24 revealed:
-Diagnoses included fall with rib fracture and hip fracture on 9/29/24.
-Resident #1 was intermittently disoriented.
-Resident #1 was non-ambulatory.

Review of Resident #1's previous FL-2 dated 06/04/24 revealed:
-Diagnosis included encephalopathy, hypoglycemia, acute sacral fracture, urinary retention, coronary artery disease, chronic macrocytic anemia, benign prostatic hyperplasia, and chronic constipation.
-Resident #1 was intermittently disoriented.
-Resident #1 was ambulatory with walker.

Review of Resident #1's Care Plan dated 03/27/24 revealed:
-Resident #1 needed limited assistance with ambulation/locomotion.
-Resident #1 needed limited assistance with transferring.
-Resident #1 used a wheelchair.

Review of incident reports for Resident #1 revealed the resident had a fall on 11/18/24, 11/21/24, 11/22/24, 12/31/24, and 1/10/25.

Refer to the interview with the Administrator on 01/16/25 at 1:06pm.

Refer to the interview with the RCC on 01/20/25 at 11:00am revealed:
-She faxed the 01/10/25 incident report to DSS on Saturday 01/11/25.

-Resident #1 fell on 09/29/24 and no incident report was completed.
-She did not know why the staff did not complete incident reports on Resident #1.

2. Review of Resident #2's FL-2 dated 07/19/24 revealed:
-Diagnosis included vitamin B12 deficiency, muscle weakness, atrial fibrillation, Parkinson's disease, essential hypertension, cognitive communication deficit.
-Resident #2 was constantly disoriented.
-Resident #2 was semi-ambulatory.

Review of Resident #2's Care Plan dated 12/15/23 revealed:
-Resident #2 was totally dependent with ambulation.
-Resident #2was extensive assistance with transferring.

Review of incident reports for Resident #2 revealed the resident had a fall on 01/12/24, a skin tear on 11/19/24, and a fall on 11/27/24.

Refer to interview with RCC on 01/20/25 at 11:00am revealed:
-She did not get an incident report on Resident #2's fall in June.

Interview with Administrator on 01/16/25 at 1:06pm revealed:
-It was the Resident Care Coordinator (RCC) responsibility to send the incident reports to the Department of Social Services.
-The RCC faxed the 01/10/25 incident report to DSS.

Interview with the RCC on 01/20/25 at 11:00am revealed:
-It was her responsibility to send incident reports to DSS.
-She did not follow up with a phone call or email to DSS.
-She did not send other incident reports to DSS because she did not know about the other incident reports.

IV. Delivered Via:	Hand delivered	Date: 02/13/25
DSS Signature:	Erin Perez / Erin Perez	Return to DSS By: 03/05/25

V. CAR Received by:	Administrator/Designee (print name): Jarrett Piper	
	Signature: COO	Date: 2/13/25

	Title: Administrator

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

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

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