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A4708	19 CSR 30-86.047(10) Care to Meet Resident Needs or Discharge The facility shall not admit or continue to care for residents whose needs cannot be met. If necessary services cannot be obtained in or by the facility, the resident shall be promptly referred to appropriate outside resources or discharged from the facility. I/II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary services to continue to care for one resident (Resident #6), in a review of six sampled residents. Staff identified the resident had an overall decline, which affected his/her ability to bear his/her own weight and actively participate in transfers. Staff identified the resident would benefit from a mechanical lift for transfers, however, the facility did not allow this type of transfer in the facility. Staff did not refer the resident to outside resources or discharge the resident when they could not meet the resident's needs. Staff continued to transfer the resident in an unsafe manner by lifting the resident. The facility census was 41. Review of the facility policy, Limited Lift/Resident Handling Policy, updated 03/2017, showed the following: -It is the policy of this company/facility to provide a safe and secure environment for employees and residents. Thus, the Resident Handling Policy exists to ensure a safe working environment for resident handlers as well as increase safe transfers and mobility for residents; -Initial screening will be performed on all residents to assess transfer/ambulatory status. This status should be reviewed and updated as needed and should be evaluated for accuracy	A4708		

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during the resident's care plan;
-Gait belt (an assistive strap placed around the waist and used by caregivers to secure a handhold to safely guide and transfer individuals with mobility or balance issues) use is mandatory for all resident handling with the exception of bed mobility or medical contraindications;
-Each employee will receive training with return demonstration on transfers of a resident with assistance of one and two staff members and the proper position and placement of gait belt.

1. Review of the facility document, Negotiated Service Agreement, dated 09/19/22 and signed by Resident #6's legal representative, showed the following:
-The facility is prohibited from accepting or retaining residents with certain behaviors or needs. Therefore, discharge planning will be coordinated with the resident and family if these needs occur after admission;
-Requires skilled nursing services;
-Requires more than one person to simultaneously physically assist the resident with any activity of daily living, with the exception of bathing and transferring;
-Is bed-bound or similarly immobilized due to a debilitating or chronic condition.

Review of the resident's undated medical diagnosis document showed the resident had a diagnosis of Alzheimer's disease and cerebral infarction (stroke).

Review of the resident's Individual Evacuation Plan (IEP), dated 11/07/25, showed the following:
-Oriented only to person;
-The resident used assistive devices for mobility and required one-to-two staff assistance for all

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transfers;
-Due to physical immobility, the resident was aware, once educated, that he/she needed to evacuate;
-The resident needed one-to-two staff assistance to transfer to a Broda chair (specialized reclining chair propelled by staff) and then required one staff to push him/her to an area of refuge;
-The resident was resistive to care at times and may not understand the need to quickly evacuate;
-The resident required one to two staff assistance for all transfers.

Review of the resident's nursing progress note, dated 12/09/25 at 2:25 A.M., showed the following:
-Staff assisted the resident in the bathroom. The resident became agitated, cursed and hit a staff member;
-The staff member called for help. Another staff member assisted and put the resident in the wheelchair and put the resident in his/her bed;
-Please note, the resident will now be a two-person assist;
-Do not assist the resident without another staff member;
-Fall risk.

Review of the resident's progress note, dated 02/19/26 at 8:03 A.M., showed the following:
-The resident became aggressive, agitated, and combative with staff, and kept moving his/her foot off the foot pedal of the wheelchair in order to slide out of the wheelchair;
-Staff had to pull the resident up in his/her wheelchair several times over the morning;
-The resident refused all care by staff;
-Staff attempted to redirect the resident but

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A4708	Continued From page 3 he/she started cussing and swung his/her arm and did not allow staff to help keep him/her safe; -Three staff members put the resident to bed. Review of the resident's March Monthly Summary, dated 03/01/26, showed the following: -The resident could not meet the path of safety; -The resident had not demonstrated at the monthly fire drill the ability to meet path of safety; -The resident had a deterioration in physical/mental status over the past month that interfered with the resident's ability to meet path of safety. Review of the resident's nursing progress note, dated 03/11/26 at 5:45 P.M., showed the following: -Staff observed the resident in the main common area in front of his/her Broda chair on the floor on his/her back; -No injuries noted; -Two staff assisted the resident up to the Broda chair with a gait belt. Review of the resident's nursing progress note, dated 03/14/26 at 8:30 P.M., showed the following: -Staff discovered the resident lying flat on his/her back, with his/her legs fully extended, in front of his/her bed, and his/her feet faced the bed; -No injuries noted. Review of the resident's hospice face-to-face exam, dated 03/26/26, showed the following: -The resident continued to decline with increased dependence for activities of daily living (ADLs); -The resident required two staff for transfers; -He/She continued to weaken gradually due to disease processes.	A4708		

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A4708	Continued From page 4 Review of the resident's EMR nursing progress note, dated 04/02/26 at 4:05 P.M., showed the following: -The resident was found on the floor; -The resident appeared to have slid out of his/her bed; -No known injuries were found. Review of the resident's nursing progress note, dated 04/15/26 at 7:35 P.M., showed the following: -The resident was on the floor on the fall mat near his/her bed and lay on his/her back; -No obvious injuries were noted; -Two staff assisted the resident off the floor with a gait belt. Review of the resident's nursing progress note, dated 04/20/26 at 9:27 A.M., showed the Director of Nursing (DON) documented the following: -Notified the Executive Director (ED) of concerns with resident's transfers; -She assisted the staff to transfer the resident; -The resident did not assist with transfers, and the weight of the transfers was on her and one other staff member; -Educated the ED the facility should hold a care plan regarding this matter. Review of the resident's Monthly Summary, dated 05/01/26, showed the following: -The resident's functional status (activities of daily living, ADLs) had deteriorated; -The resident used a Broda chair; -The resident was incontinent of urine, required assistance of two staff for toileting needs; -At that time, due to safety concerns for staff and the resident, staff were not able to toilet this	A4708		

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A4708	Continued From page 5 resident on the toilet. Staff were to check and change the resident every two hours as this task could be completed with the resident in bed; -The resident was incontinent of bowel and required assistance of two staff for toileting needs. Review of the resident's IEP, dated 05/13/26, showed the following: -Only oriented to person; -The resident required assistance of two staff with a gait belt for all transfers due to safety; -The resident no longer assisted with transfers, and often left staff to carry all of his/her weight; -The resident needed assistance of two staff with a gait belt to transfer to Broda chair and then required one staff to push him/her to area of refuge; -The resident was no longer able to get to the area of refuge on his/her own; -The resident was resistive to care at times and may not understand the need to quickly evacuate; -The resident depended on two staff entirely for transfers. Review of the resident's nursing progress note, dated 05/13/26 at 10:00 A.M., showed the DON documented the following: -The resident required total assistance from staff for all transfers; -The resident was no longer able to assist with transfers; -Current transfers were not comfortable for the resident due to placement of gait belt due to the resident's contracted left arm from a previous stroke; -The resident was not able to bear weight during transfers, making transfers no longer safe.	A4708		

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A4708	Continued From page 6 Review of the resident's nursing progress note, dated 05/13/26 at 10:15 A.M., showed the DON documented the following: -During the care plan, the resident's family was notified the resident required skilled nursing, with the biggest concern being safety related to transfers; -Over the last few months, the resident required more assistance with transfers; -The safest transfer was a gait belt transfer with assistance of two staff; however, this was not safe as the resident did not bear weight on many occasions. Review of the resident's nursing progress notes, dated 05/17/26 at 09:17 A.M., showed staff documented emergency medical services (EMS) arrived to transport the resident to the hospital for evaluation of a left breast lump. EMS stated it appeared the resident erupted his/her pectoral (muscle). Review of the resident's nursing progress notes, dated 05/17/26 at 05:31 P.M., showed staff documented the resident was admitted to the hospital. During an interview on 05/19/26 at 1:10 P.M. and 4:45 P.M., Level I Medication Aide (LIMA) A said the following: -The resident required assistance from two staff for transfers; -The resident's legs were weaker the last couple of months, and it was more difficult to transfer him/her; -He/She thought the resident would benefit from a Hoyer lift (a mechanical lift used to transfer residents who cannot bear weight from one	A4708		

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position to another) the last month or so, but he/she was told the facility did not allow Hoyer lifts;
-It took all the staff's strength to transfer the resident;
-He/She first noticed the resident's decline in March or April 2026;
-The DON was aware of the resident's transfer problems because she helped staff transfer the resident before.

During an interview on 05/20/26 at 4:50 P.M., LIMA B said the following;
-The resident was not able to bear his/her own weight;
-The resident had physically declined for several months;
-It took two staff and a gait belt to transfer the resident;
-He/She had to use his/her own strength for the resident's transfers;
-The resident could not use his/her left side due to a history of a stroke.

During an interview on 05/20/26 at 9:17 A.M., Certified Nurse Assistant (CNA) C said the following:
-He/She noticed a decline in the resident over the past three weeks or so;
-The resident required two staff and a gait belt for transfers;
-He/She had to use his/her own strength when he/she assisted the resident to transfer, because the resident's legs slid out from under him/her.

During an interview on 05/20/26 at 10:40 A.M., Registered Nurse (RN) E said the following:
-The DON reported the resident had increased difficulty with transfers in the last month or so;

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A4708	Continued From page 8 -Staff had to supply the physical strength to transfer the resident; -He/She mentioned the resident needed a Hoyer lift but staff said Hoyer lifts were not allowed in the facility because the facility was not a skilled nursing facility. During an interview on 05/19/26 at 02:20 P.M., the DON said the following: -It was more difficult to transfer the resident with a two-person assist and gait belt the past couple of months. The resident had physically declined; -She asked about a Hoyer lift for the resident, but the Executive Director (ED) said a mechanical lift was not allowed at the facility; -She mentioned to the resident's family in March 2026 that it had become more difficult for staff to get the resident up; -She had asked the hospice staff in March 2026 for additional assistance to care for the resident, so the resident could remain at the facility, but hospice could not provide additional staff; -Staff had to lift the resident for transfers because the resident's legs dragged; -A Hoyer lift would have been the safest mode of transfer for the resident when it became more difficult for two staff to transfer the resident. During an interview on 05/20/26 at 1:00 P.M., the ED said the following: -On or around 05/09/26, the DON told her the resident had physically declined and had difficulty with transfers. Staff reported the resident required assistance from two staff; -She was not aware of the hospice face-to-face exam on 03/26/26 that showed the resident continued to decline, with increased dependence for ADLs, required two staff to transfer, lived a bed-to-wheelchair existence, or that the resident	A4708		

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A4708	Continued From page 9 continued to weaken gradually due to his/her disease processes; -He/She would have expected staff to inform her of any decline in a resident's status at the time it occurred; -The regional staff told her the facility could not utilize Hoyer lifts for transfers per their company policy; -The resident would benefit from a Hoyer lift for safe transfers; -She instructed the resident's legal representatives that the resident required a higher level of service during a care plan meeting on 05/13/26. MO262397	A4708		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure for reporting an injury of unknown origin to the state agency (SA) for one resident (Resident #6), in a review of six sampled residents. The facility census was 41.	A8023		

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A8023	Continued From page 10 Review of the facility policy, Reporting Abuse to Community Management, dated 06/10/19, showed the following: -It is the responsibility of the facility's employees and community consultants to promptly report any incident or suspected incident of resident neglect or abuse, including injuries of unknown source/origin, to community management; -All alleged or suspected cases should be reported to the respective State agency. Review of the facility policy, Abuse Investigation, dated 06/10/19, showed the following: -Reports of resident injuries of unknown origin are to be reported to Community management and thoroughly investigated as soon as possible; -Should an injury of an unknown source be reported, the administrator, or his/her designee should appoint a member of management to investigate the alleged incident. 1. Review of the resident's medical diagnosis list showed the resident's diagnoses included Alzheimer's disease and cerebral infarction (stroke). Review of the resident's nursing progress note, dated 04/02/26 at 4:05 P.M., showed staff found the resident on the floor. The resident appeared to have slid out of his/her bed. No known injuries found. Review of the resident's nursing progress note, dated 04/15/26 at 7:35 P.M., showed the resident was on the floor on the fall mat near his/her bed, and lay on his/her back. No obvious injuries noted.	A8023		

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A8023	Continued From page 11 Review of the resident's medical record showed no documentation staff identified bruising on the resident's skin following the fall on 04/15/26 through 05/01/26. Review of the facility document, Monthly Summary, dated 05/01/26 at 10:24 A.M., the following: -The resident's functional status/activities of daily living (ADLs) had deteriorated; -The resident used a Broda chair (specialized reclining chair propelled by staff); -Alert and oriented to self only; -Skin: bruising left shoulder (front), abdomen; -Fall since last review: 04/02/26 non-injury and 04/15/26. No obvious injury at time of falls but bruising noted later on left shoulder/armpit area and left abdomen near ribs. No complaints of pain. Review of the resident's record showed no documentation staff notified administration of the bruise identified on 05/01/26 and no documentation staff conducted a thorough investigation into the potential cause of the resident's bruise noted in the resident's monthly summary dated 5/01/26. Review of the resident's nursing progress note, dated 05/09/26 at 07:56 P.M., showed the following: -Bruising noted to left arm pit area, left rib cage area, left arm, and left breast. Notified Director of Nursing (DON); -DON asked staff to call the hospice nurse to evaluate the bruises; -The bruises occurred on the resident's left side which was affected by his/her stroke.	A8023		

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Review of the resident's nursing progress note, dated 05/09/26 at 8:00 P.M., showed the DON documented the following:
-Notified the Executive Director (ED) of bruising on the resident's left side per staff report;
-Contacted the resident's hospice staff and requested for him/her to visit the resident per the ED's request;
-The hospice nurse said with the resident's recent falls and the concern of bruising, an evaluation/visit could wait until the next day. (The resident's last documented fall was on 4/15/26);
-The hospice nurse asked the DON to educate the family that the bruising could be terminal bruising (also known as terminal skin failure, refers to rapidly developing dark, bruised-looking skin lesions that appear on a person's body in the final days or weeks of life) or due to circulation issues and that a hospice nurse would be out the next day for evaluation.

Review of the resident's nursing progress note, dated 05/09/26 at 8:05 P.M., showed the DON documented the following:
-She contacted the resident's family about the bruising down the left side of the resident's body, and she was unsure what caused the bruising;
-The resident's family member asked if this bruising was normal. The DON said she wanted the hospice nurse to look at the resident due to not being sure how the resident ended up with bruising down his/her left side before saying for sure what they were dealing with.

Review of the resident's nursing progress note, dated 05/10/26 at 8:34 A.M., showed the DON documented the following:
-Hospice staff arrived to assess the resident for concerns of new bruising;

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A8023	Continued From page 13 -Per the hospice nurse, he/she felt the bruising was consistent with a fall. (The resident's last fall was documented on 4/15/26, 24 days prior); -Staff added the resident to post-observation for a fall due to bruising on left side. Review of the resident's nursing progress note, dated 05/11/26 at 2:33 P.M., the DON documented the following: -A different hospice nurse saw the resident today, and he/she agreed the bruises were from a previous fall and were healing. (The resident's last fall was documented on 4/15/26, 24 days prior); -Educated staff to use gait belt to transfer resident to avoid further bruising under his/her arms. Review of the resident's nursing progress note, dated 05/17/26 at 6:30 A.M., showed the DON documented the following: -Staff notified her of a large lump over the resident's left breast; -Staff reported the area felt hard to the touch, and the resident did not seem to be in pain; -She notified the ED and family; -The resident's hospice staff said he/she would evaluate the resident mid-morning. Review of the resident's nursing progress note, dated 05/17/26 at 8:49 A.M., showed the DON documented the following: -The resident's hospice nurse, Registered Nurse (RN) E, arrived to assess the resident and said he/she had no idea what caused this (the lump over the resident's left breast); -The DON called the family, and they requested the resident be sent to the emergency room (ER) for evaluation.	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26349	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK ASSISTED LIVING	161 PROFESSIONAL PARKWAY TROY, MO 63379

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A8023	Continued From page 14 Review of the resident's nursing progress note, dated 05/17/26 at 9:17 A.M., showed the DON documented emergency medical services (EMS) arrived to transport the resident to the hospital and said it appeared the resident had erupted (exploded) his/her pectoral (muscle, the main skeletal muscles that connect the front of the chest to the bones of the upper arm and shoulder). Review of the resident's nursing progress note, dated 05/18/26 at 10:44 A.M., showed the DON documented she spoke with the hospital social worker, and the resident had a hematoma (a localized collection of clotted or pooled blood that leaks outside of a blood vessel and builds up within an organ, tissue, or body space) of the left chest wall. During an interview on 05/19/26 at 1:10 P.M., Level I Medication Aide (L1MA) A said the following: -The resident had random bruises on his/her left side about two to three weeks ago -He/She was not sure what caused the bruises, but the resident had been getting weaker and needed more help with transfers; -The resident required two staff and a gait belt for transfers; -The resident had a history of a stroke and could not move his/her left side and did not have feeling there; -He/She felt a lump on the left side of the resident's shirt on 05/17/26 and it was hard to touch; -He/She lifted the resident's shirt, and the raised area was hard to touch, yellow-green and purple in color. The resident did not complain of pain	A8023		

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A8023	Continued From page 15	A8023		

when he/she touched the area;
-He/She bathed the resident a couple of days before, and the area was not there then;
-He/She reported the area right away to the DON;
-The resident was transferred to the hospital later that morning.

During an interview on 05/19/26 at 02:20 P.M., the DON said the following:
-The resident's last documented fall was on 04/15/26;
-The resident did not have bruising noted during the post-fall documentation period;
-Staff notified her by phone on the evening of 05/09/26 that the resident had bruises along his left arm pit area, left rib cage, left arm, and left breast;
-She thought the bruise under the left arm pit was possibly from a transfer by the resident's hospice shower aides, because she saw them transfer the resident one day under his/her arms without a gait belt;
-She was unsure what caused the other bruises;
-She did not come in to assess the resident;
-She notified the ED who said the resident's hospice staff should go the facility and evaluate the resident;
-She felt it was the responsibility of the hospice staff to evaluate the resident;
-The resident's hospice staff assessed the resident the next day (05/10/26) and said the bruises were probably related to his/her previous falls;
-A second hospice nurse saw the resident on 05/11/26 and thought the bruises were also related to previous falls;
-She was notified on 05/17/26 of a large, hard area on the resident's left chest wall;

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A8023	Continued From page 16 -She was unsure what would have caused this large, hard area; -She notified the resident's hospice staff who came to the facility later that morning to assess the resident; -The hospice nurse was also unsure what caused the large, hard area on the resident's left chest wall; -The resident did not have any recent falls but still had bruising along his/her left side; -The resident was transferred to the hospital; -Bruises and/or injuries of unknown origin should be reported to administration immediately after occurrence; -Bruises and/or injuries of unknown origin could be signs of abuse; -She was not sure if bruises and/or injuries of unknown origin was reportable to the state agency (SA), or if there was a time frame involved for reporting, she just knew she was required to report these issues to the ED. During an interview on 05/20/26 at 01:00 P.M., the Executive Director (ED) said the following: -She was first made aware of bruising on the resident's left side of the body on 05/09/26 by the DON; -She thought the bruise under the left arm pit was possibly due to staff transferring the resident under his/her arms, as reported by the DON, but was not sure what caused the other bruises; -She did not come into the facility to see the resident; -She relied on the hospice nurse's assessment to help identify the cause of the bruising; -The resident's hospice nurse felt the bruising was from a previous fall, so the ED did not feel the bruises were from an unknown origin; -She was not aware that the hospice nurse did	A8023		

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A8023	Continued From page 17 not see the resident on 05/09/26 when the bruises were first identified; -She was notified when staff found a large, hard lump on the resident's left chest, and the resident was sent to the hospital for further evaluation; -She was not sure what could have caused the large, hard lump on the resident's left chest wall; -Bruises and/or injuries of unknown origin should be reported and investigated by the facility when they occurred; -Bruises and/or injuries of unknown origin could potentially be signs of abuse. MO262397	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	Sugar Creek Assisted Living by Americare
Street Address, City, Zip:	161 Professional Parkway Troy, MO 63379
Date of Survey:	05/20/2026

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	26349

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4708	In response to 19CSR 30-86.047(10) Care to Meet Resident Needs or Discharge **Immediate Action:** Resident requiring two or more staff assist to transfer, use of Broda chair, was issued a 30-day Discharge on 05/19/2026 and was to be discharged to a skilled nursing facility on 06/18/2026. Resident family elected to discharge on 06/03/2026 to a VA facility. Executive Director and Health & Wellness Director were educated on 06/19/2026 by Director of Risk, on admission and discharge criteria for assisted living. The facility shall not admit or continue to care for residents whose needs cannot be met. Residents exceeding two-person transfer, require referral to an appropriate outside resources or appropriate discharge to a community that can meet the residents needs. Additional policies reviewed included: • Pre-Admission Assessment • State Community Based Assessments at admission, semi-annual and with each change in condition • Change in Condition • Incident Accident Reporting (including bruising of unknow origin) • Individual Evacuation Plan • Individual Service Plan • Limited Lift/Resident Handling Policy • ANE Policies and Checklist Health & Wellness Director as completed a review of all residents to assure no additional residents require services or care outside the scope of that of assisted living.	06/24/2026

Executive Director 6-23-26

	All current staff in-serviced on or before 6/24/2026 by Executive Director, Health & Wellness Director and or Hospice Liason on or before 6/24/2026. • Limited Lift/Resident Handling Policy • Transfer Techniques using a gait belt • What constitutes possible A/N (including bruising of unknow origin) • ISP/Care Plans and IEP • Immediate notification to Executive Director and or Health & Wellness Director when residents care exceeds that of Assisted Living or when residents require more than 2 staff to safely transfer. **Ongoing Compliance:** Health & Wellness Director or designee for in absence of will assure ongoing compliance **through** completing monthly assessments and reviews of all resident during their Monthly Summary, and resident identified with a change of condition that requires more than 2 person assist with transfers or ADLs and or requires services and needs greater than of that of an assisted living, shall be given an appropriate notice of discharge to a community that can meet the resident's needs. **Completion Date:** 06/24/2026	
A8023	In response to 19CSR 30-88.010(23) Develop/Implement A/N Policies **Immediate Action:** Executive Director and Health & Wellness Director were provided in-service on policies of A/N, Steps to be taken for A/N investigation & A/N Checklist including (bruising of un-known origin requiring further investigation and reporting to DHSS), Incident Reporting including (bruising of unknow origin constituting investigation of possible A/N). In-servicing completed by Director of Risk on 6/19/2026. All current staff in-serviced on or before 6/24/2026 by Executive Director and Health & Wellness Director on • A/N and immediately reporting any bruising of resident, incidents accidents or any other possible witnessed or unwitnessed A/N. • Incident Reporting (including bruising of unknown origin) • Limited Lift/Resident Handling Policy	6/24/2026

	• Use of gait belt with transfers and proper placement of gait belt on resident to decrease opportunity to injury and or bruising. • Immediately reporting to management any resident requiring 2 or more staff to transfer or any other services or needs outside of what an assisted living is licensed to provide. **Ongoing Compliance:** Executive Director will assure ongoing compliance through conducting a thorough investigating of all suspected or witnessed A/N including bruises of unknow origin. Executive Director will review all incident reports and investigate all incidents to assure appropriate steps are taken to protect the resident. Investigation shall include use of ANE Checklist which guides Executive Director in all steps to take (including notification to state agency. **Completion Date:** 6/24/2026	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.