



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC  
LEGAL ENTITY

To operate THE NEIGHBORHOODS AT WALDEN'S VIEW  
NAME OF FACILITY OR AGENCY

Located at 7990 US ROUTE 30, NORTH HUNTINGDON, PA 15642  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

\_\_\_\_\_  
ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

To provide Personal Care Homes  
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 40  
(MAXIMUM CAPACITY)  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

**Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

Restrictions: \_\_\_\_\_

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes  
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from January 3, 2020 until January 3, 2021,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446810**

Robert E. Robinson  
ISSUING OFFICER

[Signature]  
DEPUTY SECRETARY

**NOTE:** This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



January 3, 2020

Mr. Michael Haas  
President  
Walden's View North Huntingdon, OPCO, LLC  
7990 Route 30 East  
North Huntingdon, Pennsylvania 15642

RE: The Neighborhoods at Walden's View  
Certificate #: 446810

Dear Mr. Haas:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on October 2, 2019 and December 9, 2019, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock". The signature is fluid and cursive.

Kevin Hancock  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

## Violation Report

### Facility Information

Name: *THE NEIGHBORHOODS AT WALDEN'S VIEW*  
 Address: *7990 US ROUTE 30,, NORTH HUNTINGDON, PA 15642*  
 County: *WESTMORELAND*                      Region: *WESTERN*

License Number: *44681*

### Administrator

Name: *TABITHA LINSENBIGLER*                      Phone: *(724)863-2600 ext. 8654*                      Email: *tabatha.linsenbigler@waldensviewseniorliving.com*

### Legal Entity

Name: *WALDEN'S VIEW NORTH HUNTINGDON OPCO LLC*  
 Address: *7990 US ROUTE 30, NORTH HUNTINGDON, PA, 15642*

### Certificate(s) of Occupancy

Type: *I-2*                      Date: *01/19/2016*                      Issued By: *TWP. OF NORTH HUNTINGTON*

### Staffing Hours

Resident Support Staff: *0*                      Total Daily Staff: *60*                      Waking Staff: *45*

### Inspection

Type: *Full*                      BHA Docket #:                      Notice: *Unannounced*  
 Reason: *Provisional*

### Inspection Dates and Department Representative

*10/02/2019 - On-Site: Joe Eveges, Deb McConnell, Belinda Graziano*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *40*                      Residents Served: *30*

#### Secured Dementia Care Unit

In Home: *Yes*                      Area: *BUILDING WIDE*                      Capacity: *40*                      Residents Served: *30*

#### Hospice

Current Residents: *4*

#### Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>30</i>
Diagnosed with Mental Illness: <i>4</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>30</i>	Have Physical Disability: <i>0</i>

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The resident privacy coding for the licensing inspection summary dated 4/9/19 was posted publicly on the home's bulletin board listing multiple resident's names to include: resident #1, resident #2 and resident #3.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately privacy coding for inspection summary dated 4/9/19 was removed by BHSL surveyor

Moving forward to stay in compliance with regulation 2600.17 the administrator and resident care coordinator will review and initial the last page of the inspection summary prior to posting in a public area to ensure privacy coding is removed.

A designated staff personnel will inspect all areas of the home on a monthly basis where resident records are kept to ensure records are confidential. Documentation will be kept. All staff will be educated on record confidentiality by Nov. 30th 2019.

*JR* 11-21-19

Legal Entity Representative

*Tabatha Linsenbigler*  
Signature

Tabatha Linsenbigler PCHA, LPN

Printed Name and Title

11/01/2019

Date

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The above plan of correction is approved as of 11/26/19  
(Date)

Plan of correction implementation status as of \_\_\_\_\_  
(Date)

The above plan of correction was approved by *SE*  
(Initials)

Implemented

Not Implemented

82a - Poisonous Materials

Regulations

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

There was an unlabeled spray bottle on top of cabinets in the shower room in Garden House, approximately 1/5 full of liquid.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The spray bottle found on top of the cabinet in garden shower room was immediately removed during inspection. Housekeeping and staff will be educated on poisonous materials being stored in their original, labeled containers.

Housekeeping will do monthly audits on all poisonous material to ensure poisonous liquid is in original, labeled containers and document. (see attached document)

Housekeeping and staff will be trained to use original labeled container from manufacture and will be completed by Nov. 30th 2019. Designated housekeeping staff will keep monthly audits on poisonous material and documentation will be kept. *TA 11-21-19*

Legal Entity Representative

*Tabatha Linsenbigler*  
Signature

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Not Implemented

85a - Sanitary Conditions

Regulations

2600.  
85.a. Sanitary conditions shall be maintained.

Description of Violation

There was an unlabeled towel hanging in the common bathroom between bedroom #208 and bedroom #209.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Unlabeled towel immediately removed from common bathroom.  
Resident residing in room #208 requires minimal assistance with personal hygiene, staff will check and remove any linens in common bathroom following resident completing hygiene. (see attached document)

DCS will ensure towels will be hung on the hooks located on each bathroom door and monitor each bathroom daily. Individual hooks are located on each bathroom door for staff/residents to utilize. Labels will be added with resident names by Dec. 5th 2019. Staff education on sanitary conditions will be completed by Nov. 30th 2019. *J 11-21-19*

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91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers, to include the nearest hospital and fire department, on or by the black corded telephone on the shelf in the home's kitchen.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Emergency telephone numbers were posted on the base of the telephone in the homes kitchen on Nov. 1 2019.

A monthly audit will be done by the administrator or resident care coordinator to ensure all phones within the home have emergency telephone numbers listed. The administrator or resident care coordinator will sign off on the following document. (Please see attached document) Documentation will be kept.

Staff will be educated on emergency telephone numbers by Nov. 30th 2019 and documentation will be kept. *J 11-21-19*

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101j5 - Bedside Table/Shelf

Regulations

2600.

- 101.j. Each resident shall have the following in the bedroom:
  - 5. A bedside table or a shelf.

Description of Violation

There was no bedside table accessible in bedroom #208. The nightstand was approximately 4 feet from the resident's bed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

During inspection survey maintenance director immediately moved nightstand beside residents bed.

Moving forward the maintenance director, administrator or resident care coordinator will sign off on a weekly walk through form to ensure nightstands are within reach of residents beds. (Please see attached document)

Documentation of weekly walk through will be kept, staff will be educated on bedside table/shelf by Nov. 30th 2019.

*JH 11-21-19*

Legal Entity Representative

*Tabatha Linsenbigler*  
Signature

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11/01/2019  
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Implemented

Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

No operable lamp or other source of lighting which can be turned on/off at bedside was present in bedroom #208. The bedside lamp was approximately 4 feet from the resident's bed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

During inspection survey maintenance director immediately moved nightstand with lamp within reach to residents bed.

The maintenance director, administrator or resident care coordinator will sign off weekly on attached document to ensure nightstand and lamps are within reach to beds.

Documentation will be kept on weekly walk through on lamps, staff will be educated on lighting/operable lamp by Nov. 30th 2019.

*JR 11-21-19*

Legal Entity Representative

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Signature

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103f - Refrigerator/Freezer Temps

Regulations

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The temperature of the walk in freezer in the home's kitchen was 8 degrees Fahrenheit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Kitchen obtained additional reading following lunch at 3pm freezer temperature read -2 degrees F. Kitchen staff will take temperature in the homes freezer and refrigerator located in the homes kitchen once in the morning and once in the afternoon, signing off daily on attached document to verify temperatures are within appropriate range. If temperatures are not within range the kitchen staff will immediately notify maintenance.

Dietary staff and direct care staff will be educated on refrigerator/freezer temps by Nov. 30th 2019, documentation will be kept.

*JH* 11-21-19

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Not Implemented

107a - Emergency Preparedness

Regulations

2600.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home does not have the emergency preparedness plan for the local municipality.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Initial letter received 10/2/2019 from township denied request to provide community with EOP. After multiple attempts via email and several phone calls to emergency management coordinator recieved EOP on 10/16/2019. The EOP will be located in the common area in the glass case and a copy will be available in the administrators office. Administrator will update EOP as needed. (see attached documents)

Glass case located in the common area is unlocked and accessible. The administrator or resident care coordinator will complete a monthly walk through to ensure EOP is located in glass case, documentation will be kept. (see attached documentation) Staff will be educated on EOP by Nov. 30th 2019.

*JH* 11-21-19

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121a - Unobstructed Egress

Regulations

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit door leading from the Sage House hallway to the dining room was locked. There is an emergency exit in the dining room which cannot be accessed from the Sage House area when this door is locked.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Immediately sage house hallway dining room was unlocked. Recent renovation taking place at community, construction workers educated to keep emergency exit doors unlocked at all times and a clear pathway in the event of emergency.

The administrator or maintenance director will ensure dining room doors are unlocked daily. (see attached documentation)

Construction workers educated on 11/21/19 to keep egress routes unlocked and unobstructed. Staff will be educated by Nov. 30th 2019. *JR 11-21-19*

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133.1 - Exit Signs

Regulations

2600.

133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word "EXIT" in plain legible letters shall be placed at all exits.

Description of Violation

There were no exit signs visible from the common area living room indicating there were exits down the neighborhood hallways (Sage, Garden, Mountain, Lake).

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

There is a visible exit sign located above double doors in the center of the common area that leads into a gated courtyard in the event of an emergency. During inspection survey maintenance director hung temporary visible exit signs outside each hallway. Maintenance ordered LED exit/emergency signs and will install once received. (Please see attached receipt)

LED exit/emergency signs arrived to facility on 11/21/19, signs were installed on 11/22/19 by BK electric. (please see attached picture) *JA 11-21-19*

Type text here

Legal Entity Representative

*Tabatha Linsenbigher*

Signature

Tabatha Linsenbigher PCHA, LPN

Printed Name and Title

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Not Implemented

225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #6's initial medical evaluation, dated 4/15/19, indicates the following medical diagnoses: Type 2 Diabetes Mellitus, hyperlipidemia, obstructive sleep apnea, osteoporosis, and peripheral neuropathy. However, the resident's initial assessment, dated 4/17/19, does not address these diagnoses.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Type II DM was listed on initial DME and support plan. A significant change was completed with updated diagnoses; hyperlipidemia, obstructive sleep apnea, osteoporosis and peripheral neuropathy on 10/31/19. (please see attached documentation)  
A chart audit will be completed by administrator and resident care coordinator within 2 weeks on all residents within the community comparing, updating and verifying all diagnoses on initial DME are listed on initial support plan. If any errors are found a significant change will be completed.

Chart audit was completed on 11/5/19 (see attached document) The administrator or resident care coordinator completes the assessment plan if the resident care coordinator completes the assessment the administrator will review and sign off on page 14 verifying all information added on the assessment is accurate and complete. Or if the administrator completes the assessment the resident care coordinator will sign off on page 14 verifying all information added on the assessment is accurate and complete.

The resident care coordinators will be educated on assessment documentation by Nov. 30th 2019. *J 11-21-19*

Legal Entity Representative

*Tabatha Linsenbigler*  
Signature

Tabatha Linsenbigler PCHA, LPN

Printed Name and Title

11/01/2019

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The above plan of correction was approved by	<u><i>SE</i></u> (Initials)	<input type="checkbox"/> Not Implemented	

227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6's initial support plan, dated 4/17/19, was not signed by the resident nor does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Updated support plan completed on 10/31/2019 and signed by resident #6. Previous administrator did not get signature on initial support plan dated 4/17/2019, unable to obtain signature on initial support plan due to not completing form for that date and inability to determine why signature was not obtained.

Moving forward the administrator will ensure all support plans are signed by the resident or indicate the reason why signature was not obtained. Within 2 weeks the administrator and resident care coordinator will do chart audits on all residents to ensure signatures are obtained or a reason why a signature was not obtained.

Chart audit was completed on 11/5/19. (see attached document) The administrator or resident care coordinator completes the support plan. The administrator or resident care coordinator will sign off on ph.14 verifying a signature is obtained or why a signature was not obtained.

*JR* 11-21-19

Legal Entity Representative

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Signature

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(Initials)

Not Implemented

231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #5's record does not include documentation that the resident and the resident's designated person have not objected to the resident's admission to a secured dementia unit.

Resident #6's record does not include documentation that the resident and the resident's designated person have not objected to the resident's admission to a secured dementia unit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #6 was admitted to the secure dementia unit on 4-16-19 from personal care, appendix L not obtained during transfer. Family notified of error and appropriate signatures were obtained on 10-13-19 Resident #5 appendix L paperwork was in contract dated 9-17-18. (please see attached documents)

All resident contracts were reviewed to ensure all appropriate paperwork is present and accurate. The administrator will review all new resident contract upon moving into community to confirm appendix L is completed and in the residents file.

Repeat review of all resident contracts completed 11/21/2019 by administrator to verify appendix L is present. (see attached document) The administrator will sign off on appendix L on all move ins. *JR 11-21-19*

Legal Entity Representative

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