Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

January 9, 2023

[redacted]
GREER AID OPCO LLC
[redacted]

RE: CLEN-MOORE PLACE
22 WEST CLEN MOORE BOULEVARD
NEW CASTLE, PA, 16105
LICENSE/COC#: 44493

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/27/2022, 04/28/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CLEN-MOORE PLACE* **License #**: *44493* **License Expiration**: *07/11/2023*

Address: *22 WEST CLEN MOORE BOULEVARD, NEW CASTLE, PA 16105*

County: *LAWRENCE* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *GREER AID OPCO LLC*

Address: *330 N WABASH AVE SUITE 3700, CHICAGO, IL, 60611*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/25/1997* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *47* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/03/2022*

Inspection Dates and Department Representative

04/27/2022 - On-Site: [redacted]

04/28/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* **Residents Served**: *35*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

04/27/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/29/2022*

07/12/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/30/2022*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/19/2022*

Inspections / Reviews *(continued)*

01/09/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/30/2022*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted], for resident #1 indicates the resident requires 2-person assistance with transfers in/out bed/chair, toileting, ambulating and hygiene. On 2/25/22, at approximately 2:30 pm., the resident did not receive this assistance as required. Resident #1 was transferred from a chair to the bed and hygiene completed by only staff person A.

POC Submission ***Accept***

• On [redacted] staff person A was immediately terminated.
• All staff were educated on resident's #1's care needs by Care Services Manager (CSM) and Executive Director (ED) prior to resident #1's admission.
• On 2/28/22, all staff were in-serviced again on resident #1's needs regarding assistance with ADLs as indicated in the resident's assessment and support plan (RASP) by the CSM and ED. (Exhibit 1 – Inservice)
• On 2/28/22, all staff were in-serviced on current residents needs regarding assistance with ADLs as indicated in the RASPs by the CSM and ED. (Exhibit 2 – Inservice)
• Starting 6/29/22, ED or CSM will questions 2 staff members on 2 residents' needs regarding assistance with ADLs as indicated in the RASPs weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance is maintained with regulation 2600.23a. (Exhibit 3 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 2/28/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *02/28/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On [redacted], staff person A was immediately terminated.
• All staff were educated on resident's #1's care needs by Care Services Manager (CSM) and Executive Director (ED) prior to resident #1's admission.
• On 2/28/22, all staff were in-serviced again on resident #1's needs regarding assistance with ADLs as indicated in the resident's assessment and support plan (RASP) by the CSM and ED. (Exhibit 1 – Inservice)
• On 2/28/22, all staff were in-serviced on current residents needs regarding assistance with ADLs as indicated in the RASPs by the CSM and ED. (Exhibit 2 – Inservice)
• Starting 6/29/22, ED or CSM will questions 2 staff members on 2 residents' needs regarding assistance with ADLs as indicated in the RASPs weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance is

23a - Activities of Daily Living Assistance (continued)

maintained with regulation 2600.23a. (Exhibit 3 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 2/28/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *02/28/2022*

26b - Quality Management Plan Content

2. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management review dated 1/2022, did not address reportable incidents and conditions and staff person training.

POC Submission ***Accept***

• On 4/27/22, ED notified the Regional Director of Care Services (RDCS) that the current template for the Quality Management Plan did not address reportable incidents and conditions and staff person training.
• On 4/28/22, RDCS provided the ED with a new template for the Quality Management Plan which addresses reportable incidents and conditions and staff person training. RDCS also sent the new template to EDs in all Pennsylvania communities. (Exhibit 4 – Template)
• Starting with April 2022's Quality Management Plan meeting, the new template for the Quality Management Plan will be utilized by the ED for the Monthly Quality Management Plan meetings.
• Completion Date: 5/31/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/31/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On 4/27/22, ED notified the Regional Director of Care Services (RDCS) that the current template for the Quality Management Plan did not address reportable incidents and conditions and staff person training.
• On 4/28/22, RDCS provided the ED with a new template for the Quality Management Plan which addresses

26b - Quality Management Plan Content (continued)

reportable incidents and conditions and staff person training. RDCS also sent the new template to EDs in all Pennsylvania communities. (Exhibit 4 – Template)
• Starting with April 2022's Quality Management Plan meeting, the new template for the Quality Management Plan will be utilized by the ED for the Monthly Quality Management Plan meetings.
• Completion Date: 5/31/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/31/2022*

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

[redacted], *at approximately* [redacted] *staff person A was providing hygiene care to resident #1. During this process the resident's* [redacted]*r and hospice nurse requested that staff person A make sure the resident was adequately clean. Staff person A, while in the presence of resident #1, angrily snapped back in a rude manner, telling the resident's* [redacted] *and hospice nurse, "didn't you see me wipe* [redacted]*, I'm not doing this shit anymore". Staff person A completed dressing resident #1 and angry stormed out of the resident's bedroom commenting, "I'm over with stupid people and can't wait to get the fuck out of here".*

POC Submission ***Accept***

• On 2/25/22, ED and CSM immediately began an investigation, notifying the Area Agency on Aging, Department of Human Services, and local police department of the allegation and completed the ACT-13 report.
• On [redacted]*, after interviewing witnesses and staff person A, staff person A was immediately terminated by the ED.*
• On 2/28/22, current residents were interviewed by the ED and CSM to ensure that there were no other violations of regulation 2600.42c. (Exhibit 5 – Audit)
• On 2/28/22, all employees were in-serviced by the ED on requirements set within regulation 2600.42c as well as Resident Rights, Older Adult Protective Services Act, and Abuse Reporting Requirements. (Exhibit 6 – Inservice)
• Starting 6/29/22, ED or CSM will question 2 residents to ensure they feel they are treated with dignity and respect by staff weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance is maintained with regulation 2600.42c. (Exhibit 7 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 2/28/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by

42c - Treatment of Residents (continued)

the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *02/28/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On 2/25/22, ED and CSM immediately began an investigation, notifying the Area Agency on Aging, Department of Human Services, and local police department of the allegation and completed the ACT-13 report.
• On [redacted] after interviewing witnesses and staff person A, staff person A was immediately terminated by the ED.
• On 2/28/22, current residents were interviewed by the ED and CSM to ensure that there were no other violations of regulation 2600.42c. (Exhibit 5 – Audit)
• On 2/28/22, all employees were in-serviced by the ED on requirements set within regulation 2600.42c as well as Resident Rights, Older Adult Protective Services Act, and Abuse Reporting Requirements. (Exhibit 6 – Inservice)
• Starting 6/29/22, ED or CSM will question 2 residents to ensure they feel they are treated with dignity and respect by staff weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance is maintained with regulation 2600.42c. (Exhibit 7 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 2/28/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *02/28/2022*

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Agency staff person A, hired [redacted], has not had a Pennsylvania Criminal History Check completed since 1/22/2020

POC Submission ***Accept***

• On [redacted] staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.51. No issues were noted.
• ED will review employment records, including background check, from any employee who is employed by a third-party staffing agency prior to employees being allowed to begin work at the community.
• Starting 6/29/22, ED will audit, if applicable, new employee files weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.51 is maintained.

51 - Criminal Background Check (continued)

• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On [redacted] staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.51. No issues were noted.
• ED will review employment records, including background check, from any employee who is employed by a third-party staffing agency prior to employees being allowed to begin work at the community.
• Starting 6/29/22, ED will audit, if applicable, new employee files weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.51 is maintained.
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Agency staff person A, hired [redacted] did not receive orientation on any of the required orientation training except for fire drills and evacuation procedures.

65a - FS Orientation 1st Day *(continued)*

POC Submission ***Accept***

• On [redacted] staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.65a. No issues were noted.
• ED will audit, if applicable, the files for new direct care staff persons, ancillary staff persons, substitute personnel and volunteers weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.65a is maintained.
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On [redacted] staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.65a. No issues were noted.
• ED will audit, if applicable, the files for new direct care staff persons, ancillary staff persons, substitute personnel and volunteers weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.65a is maintained.
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

65b - Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

65b - Rights/Abuse 40 Hours *(continued)*

Description of Violation

Agency staff person A, hired [redacted] did not complete any of the required orientation training.

POC Submission ***Accept***

• On [redacted] staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.65b. No issues were noted.
• ED will audit, if applicable, the files for new direct care staff persons, ancillary staff persons, substitute personnel and volunteers weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.65b is maintained.
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• On [redacted], staff person A, who was employed at the facility through a third-party staffing agency, was terminated.
• On 5/2/22, ED audited current employee files to ensure compliance with regulation 2600.65b. No issues were noted.
• ED will audit, if applicable, the files for new direct care staff persons, ancillary staff persons, substitute personnel and volunteers weekly x 4 weeks, bi-weekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.65b is maintained.
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

184a - Resident's Meds Labeled

7. Requirements

184a - Resident's Meds Labeled *(continued)*

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is prescribed, Acetaminophen, 325mg, 2 tabs 3 times a day. However, the pharmacy label for resident 1's Acetaminophen, indicates 2 tabs every 6 hours as needed for pain.

Resident #1 is prescribed, Polyethylene Glycol, daily. However, the pharmacy label for resident 1's Polyethylene Glycol, indicates once daily as needed.

POC Submission ***Accept***

• During the inspection, a change of direction sticker was placed on the pharmacy labels for resident #1's Acetaminophen and Polyethylene Glycol.
• On 5/2/22, the CSM in-serviced all staff certified to administer medications on the requirements of regulation 2600.184a. (Exhibit 8 - Inservice)
• On 5/2/22, the CSM and ED completed a MAR to Cart Review to ensure other medications were in compliance with regulation 2600.184a. No issues were noted.
• Starting 6/27/22, ED or CSM will audit 3 resident's medications to their physician's orders and MARs weekly x 4 weeks, biweekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.184a is maintained. (Exhibit 9 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.
• Completion Date: 5/2/22

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*

Document Submission ***Implemented (JW - 01/09/2023)***

• During the inspection, a change of direction sticker was placed on the pharmacy labels for resident #1's Acetaminophen and Polyethylene Glycol.
• On 5/2/22, the CSM in-serviced all staff certified to administer medications on the requirements of regulation 2600.184a. (Exhibit 8 - Inservice)
• On 5/2/22, the CSM and ED completed a MAR to Cart Review to ensure other medications were in compliance with regulation 2600.184a. No issues were noted.
• Starting 6/27/22, ED or CSM will audit 3 resident's medications to their physician's orders and MARs weekly x 4 weeks, biweekly x 4 weeks then monthly x 1 to ensure compliance with regulation 2600.184a is maintained. (Exhibit 9 – Audit)
• Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

184a - Resident's Meds Labeled (continued)

- *Completion Date: 5/2/22*

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Licensee's Proposed Overall Completion Date: *05/02/2022*