Department of Human Services
Bureau of Human Service Licensing

November 30, 2022

TWINING RETIREMENT COMMUNITY LLC

RE: HOLLAND SENIOR LIVING COMMUNITY
1400 OLD JORDAN ROAD
HOLLAND, PA, 18966
LICENSE/COC#: 14657

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/15/2022, 08/16/2022 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,

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *HOLLAND SENIOR LIVING COMMUNITY* **License #**: *14657* **License Expiration**: *08/30/2022*

Addre : *1400 OLD JORDAN ROAD, HOLLAND, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**

Legal Entity

Name: *TWINING RETIREMENT COMMUNITY LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/13/1989* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *80* **Waking Staff**: *60*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/16/2022*

Inspection Dates and Department Representative

08/15/2022 - On-Site:
08/16/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *152* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Fairview Court* **Capacity**: *27* **Residents Served**: *7*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *54*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

08/15/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/09/2022*

09/15/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2022*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/23/2022*

11/30/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/21/2022*

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

51 - Criminal Background Check

1. 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

Staff person A (hired 2020), did not have a criminal history background check completed prior to hire.

POC Submission ***Accept - 09/15/2022)***

ssue: Facility could not provide criminal background check on ancillary staff due to management takeover.

Actions: Immediately ran criminal background check.

Plan: Human Resources to pull all current employees files for verification of CBC attained.

Sustain: Checklist of new hire packet created and is signed off as completed prior to first day of work.

Licensee's Plan Completion Date: *09/22/2022*

Implemented (- 11/30/2022)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On /22, from pm to am, 52 residents were present in the home. During this time only one staff persons was present in the home who was certified in first aid, obstructed airway techniques and CPR.

On /22, from pm to am, 53 residents were present in the home. During this time only one staff persons was present in the home who was certified in first aid, obstructed airway techniques and CPR.

POC Submission ***Accept (- 09/15/2022)***

ssue: Not enough certified staff for CPR was on shift on these days.

Actions: Staff was rearranged to have 2 certified members on the floor when needed.

Plan: Campus wide CPR training is planned for 9/21/22.

Sustain: CSM / Administrator or designated other will create checklist of all nursing staff with dates of renewal of CPR by 9/30/2022

Licensee's Plan Completion Date: *09/30/2022*

Implemented - 11/28/2022)

65a - FS Orientation 1st Day

3. 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:
   1. Evacuation procedures.
   2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

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

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire e tinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

POC Submission ***Accept [redacted] 09/15/2022)***

Issue: Could not provide proof of training on [redacted] staff.
Action: Will provide orientation for this specific staff member when / if [redacted] comes back to the facility and prior to [redacted] getting on the floor.
Plan: Created an agency orientation checklist to be used prior to any [redacted] staff starting on the floor.
Sustain: Will have CSM or designated person such as the off going or oncoming nurse orient new [redacted] staff. Audit will be conducted by administrator monthly x3 months and 1x every 6 months x2 to cover the year.

Licensee's Plan Completion Date: *09/15/2022*

Implemented ([redacted] - 11/30/2022)

65b Rights/Abuse 40 Hours

4. 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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B [redacted], has been working in the home for several months. However, this [redacted] person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

POC Submission ***Accept [redacted] - 09/15/2022)***

Issue: Could not provide the 40 hour training for Staff Member B who is part of the [redacted] staff from the corporate changeover.
Action: Will provide orientation for this specific staff member when / if [redacted] comes back to the facility and prior to [redacted] getting on the floor.

65b - Rights/Abuse 40 Hours (continued)

Plan: Human Resources and Directors of departments to pull current employees files to ensure all have the training signed off by 9/30/22.
Sustain: Audits of all staff, ancillary, agency or current staff will happen monthly x 3months, then if in compliance, will happen every 6 months for 1 year.

Licensee's Plan Completion Date: *09/30/2022*

Implemented - 11/30/2022)

65c - Ancillary Staff Orientation

5. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person A, whose first day of work was /2020, did not have a general orientation to his/her specific job functions.

POC Submission ***Accept - 09/15/2022)***

ssue: Could not provide the orientation for the ancillary staff hired prior to acquisition of company.
Action: Immediately provided orientation and job responsibilities of ancillary staff.
Plan: Human Resources and Directors of departments to pull current employees files to ensure all have the training signed off by 9/30/22
Sustain: Admin / ED to audit ancillary departments every 6 months after initial plan is completed. If within compliance, audit will cease in 1 year.

Licensee's Plan Completion Date: *09/30/2022*

Implemented - 11/28/2022)

66a - Staff Training Plan

6. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2022 training year.

POC Submission ***Accept (- 09/15/2022)***

ssue: Did not have the preplanned training available and only showed the current training completed which ncluded 12 hours. Facility is now aware of what is expected.
Action: Updated the staff training plan for 2022.
Plan: Created the following year 2023.
Sustain: New staff training plans will be made in advance when previous plan goes into place by the Administrator.

Licensee's Plan Completion Date: *09/09/2022*

Implemented (- 11/28/2022)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/16/2022 at approximately 11:00am there was a 1/4 full, uncovered, unattended trash can in the Lower West trash room.

POC Submission ***Accept (09/15/2022)***

Issue: Trash can lid in trash receptacle room did not have a lid on the can.

Action: Called housekeeping and was immediately put on the trash can.

Plan: Audited all trash receptacle rooms to ensure all cans had lids. Educated housekeeping staff of importance of lids.

Sustain: Dir Housekeeping to audit the rooms biweekly x 2 months, then 1x monthly x3.

Licensee's Plan Completion Date: *09/09/2022*

Implemented (- 11/28/2022)

101j7 - Lighting/Operable Lamp

8. Requirements

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

Resident #1 does not have access to a source of light that can be turned on/off at bedside.

POC Submission ***Accept (- 09/15/2022)***

Issue: Resident #1 lamp was at the foot of bed due to change in position of bed for safety.

Action: PCP provided a letter stating a bedside lamp is not needed for this resident as there is lighting provided in the room in multiple areas and resident can not maintain function of lighting.

Plan: Check occupied apartments for proper lighting by 9/20.

Sustain: Nursing staff to notify CSM or designated persons if lamp is not at bedside table.

Licensee's Plan Completion Date: *09/20/2022*

Implemented (- 11/30/2022)

105g - Lint Removal and Duct Cleaning

9. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer’s instructions.

Description of Violation

On 8/16/22, there was an approximate 1/4 inch accumulation of lint in the lint trap of the dryer in the Upper East wing. There were no clothes in the dryer at the time.

105g - Lint Removal and Duct Cleaning (continued)

Repeat Violation Date:5/11/21

POC Submission ***Accept (█ - 09/15/2022)***

ssue: Lint was located in the dryer of the upper east wing.

Action: Immediate removal of lint, but i respectfully disagree with the amount as it had no lint in it prior to the start of shift. There was one load dried by a family member.

Plan: Note placed ON DOOR of dryer stating the lint trap must be cleared by families as well as staff.

Sustain: Audits to be completed on a weekly basis at different times to ensure the traps are cleared out.

Licensee's Plan Completion Date: *09/09/2022*

Implemented (█ - 11/28/2022)

107d - Procedure Emergency Management Agency Submission

10. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since June 2021.

POC Submission ***Accept █ - 09/15/2022)***

ssue: Could not submit the signed procedures for emergency by the management agency.

Action: Immediately contact Northampton Fire Department and requested a walkthrough.

Plan: Awaiting a date (we have provided 24 hour availability) and resent the request today.

Sustain: Director of Maintenance to start following up by June 2023 in order to get a timely reply for the inspection of the emergency management procedure.

Licensee's Plan Completion Date: *09/15/2022*

Implemented (█ - 11/28/2022)

132c - Fire Drill Records

11. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for all of the drills conducted in the home from 12/3/21 to 7/27/22 do not include the number of residents in the home at the time of the drills or the number of residents evacuated during each drill.

POC Submission ***Accept (█ - 09/15/2022)***

ssue: Not all pertinent information provided on the fire drill record.

Action: Immediately met with staff to readjust facility drills.

Plan: Will use the regulatory spreadsheet provided by DHS for recording all drills.

132c - Fire Drill Records (continued)

Sustain: Director of maintenance and/ administrator will audit the logs to ensure timing as adhered to as directed by the regulations stated in 132c.

Licensee's Plan Completion Date: *09/08/2022*

Implemented (- 11/28/2022)

132g - Fire Drills Days/Times

12. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills conducted on 1/26/22, 2/16/22, 4/27/22, 5/18/22, 6/22/22, and 7/27/22 were all Wednesdays.

POC Submission ***Accept (- 09/15/2022)***

Issue: Drills were not performed sporadically enough to ensure most staff members were included.

Action: Immediately met with staff to readjust facility drills.

Plan: Will use the regulatory spreadsheet provided by DHS for recording all drills.

Sustain: Director of maintenance and/ administrator will audit the logs to ensure timing as adhered to as directed by the regulations stated in 132g

Licensee's Plan Completion Date: *09/08/2022*

Implemented (11/28/2022)

132h - Designated Meeting Place

13. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

For all of the fire drills conducted at the home from 12/3/21 to 7/27/22, is no record on file that indicates residents evacuated to a designated meeting place away from the building or within the fire-safe area.

POC Submission ***Accept (09/15/2022)***

Issue: Not all pertinent information provided on the fire drill record.

Action: Immediately met with staff to readjust facility drills.

Plan: Will use the regulatory spreadsheet provided by DHS for recording all drills.

Sustain: Director of maintenance and/ administrator will audit the logs to ensure timing as adhered to as directed by the regulations stated in 132h.

Licensee's Plan Completion Date: *09/08/2022*

Implemented - 11/28/2022)

183e - Storing Medications

14. Requirements

183e - Storing Medications *(continued)*

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On /22, 1 round white tablet and 1 round pale yellow tablet were found loose in Lower West Cart 2.

POC Submission ***Accept - 09/15/2022)***

Issue: 2 Loose pills were located in the med cart.

Actions: Immediately removed the 2 loose pills.

Plan: Audited med carts to ensure no loose pills were located in the cart.

Sustain: Will audit carts monthly by evening staff and will report to CSM / Administrator or designee of findings.

Licensee's Plan Completion Date: *09/09/2022*

Implemented (- 11/28/2022)

185a - Implement Storage Procedures

15. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is prescribed - Give 30ml by mouth every 24 hours as needed and Give 2 tablets by mouth every 4 hours as needed for . On /22 these medications were not present on the medication cart or available for residents use.

Resident 2 is prescribed to have a glucose check completed 3 times daily. On the following dates the glucose readings do not match the numbers recorded on the glucose log.

- *8/2/22 at 5:02pm- meter reading of , log recorded as .*
- *8/3/22 at 8:43am- meter reading of log recorded as .*
- *8/3/22 at 11:55am- meter reading of , log recorded as .*
- *8/6/22 at 8:39am- meter reading of log recorded as*
- *8/6/22 at 12:47pm- meter reading of , log recorded as*
- *8/6/22 at 4:56pm- meter reading of log recorded as*
- *8/7/22 at 8:26am- meter reading of , log recorded as .*
- *8/7/22 at 11:22am- meter reading of , log recorded as .*
- *8/8/22 at 11:47am- meter reading of , log recorded as .*
- *8/10/22 at 8:59am- meter reading of log recorded as .*
- *8/10/22 at 12:18pm- meter reading of log recorded as .*
- *8/12/22 at 11:26am- meter reading of log recorded as*
- *8/14/22 at 11:23am- meter reading of , log recorded as .*

Resident 3 is prescribed to have glucose checked once per day. On 8/12/22 the glucose meter had a reading of however this was recorded as on the glucose log.

185a - Implement Storage Procedures (continued)

Resident 4 is prescribed to have fasting glucose checked once daily prior to giving the residents dose of [redacted]. On 8/12 at 11:43am, residents meter had a reading of [redacted], however the recorded number on the glucose log is [redacted].

POC Submission ***Accept [redacted] 09/15/2022)***

Issue: Incorrect documentation of glucometer readings.
Action: Immediately pulled all glucometers and audited them for accuracy.
Plan: New procedure implemented using attached spreadsheet for better accuracy when documenting.
Sustain: Audit is completed nightly on all glucometers and passed to the CSM at the start of the day. This will be an ongoing procedure.

Licensee's Plan Completion Date: *09/08/2022*

Implemented [redacted] - 11/28/2022)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed to have a glucose check completed 3 times a day and a sliding scale for insulin coverage as follows <200 no units, 200-250 2 units, 251-300 4 units, 301-350- 6 units, 351-400 8 units >400- call MD. On [redacted]/22 at [redacted] pm, residents glucometer had a reading of [redacted] however the recorded level on the glucose log read [redacted] and the resident was administered 4 units of insulin. The resident should not have received any units of insulin based on the actual reading in the glucometer. Additionally, on the following dates there is a recorded level on the glucose log however there is no corresponding reading in the residents glucometer or any other glucometer found in the home:

- *8/2/22 recorded level on the log of [redacted] at 11:30am*
- *8/5/22 recorded level on the log of [redacted] at 4:30pm*

Resident #3 is prescribed a glucose check once daily. On the following dates there is a recorded level on the glucose log however there is no corresponding reading in the residents glucometer or any other glucometer found in the home.

- *8/1/22 recorded level on the log of [redacted] at 7:30am*
- *8/2/22 recorded level on the log of [redacted] at 7:30am*
- *8/3/22 recorded level on the log of [redacted] at 7:30am*
- *8/4/22 recorded level on the log of [redacted] at 7:30am*
- *8/6/22 recorded level on the log of [redacted] at 7:30am*
- *8/7/22 recorded level on the log of [redacted] at 7:30am*
- *8/10/22 recorded level on the log of [redacted] at 7:30am*

POC Submission ***Accept [redacted] 09/15/2022)***

Issue: No documentation on the glucometers were found for above readings.
Action: Immediately addressed the nursing staff and was notified that a specific nurse was using a new one on the days [redacted] worked.
Plan: Educated all nursing staff with the regulations of 2600, not 2800 and each resident owns their own machine.
Sustain: Audit is completed nightly on all glucometers and passed to the CSM at the start of the day. This will be an ongoing procedure.

Licensee's Plan Completion Date: *09/09/2022*

187d - Follow Prescriber's Orders *(continued)*

Implemented (█ 11/30/2022)

231b - Medical Evaluation

17. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on █/21; however, the resident's previous medical evaluation was completed on █/21 and the residents most recent medical evaluation was completed on █22.

POC Submission ***Accept █ - 09/15/2022)***

ssue: a new DME was not signed off for the change from PC to MCU.

Actions: A new DME will be completed by NP when back in facility.

Plan: Pulled all MCU residents that had transferred out of the PC and noted no additional issues were found.

Sustain: CSM / Admin will follow up with obtaining new DME for significant changes.

Licensee's Plan Completion Date: *09/09/2022*

Implemented (█ - 11/30/2022)

231c - Preadmission Screening

18. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on █/21. However, the resident's written cognitive preadmission screening was completed on █/21.

POC Submission ***Accept █ - 09/15/2022)***

ssue: Prescreen wasn't completed in the time frame needed to be acceptable by regulation 231c.

Action: Did not update the prescreen as it is out of the window of acceptance.

Plan: Pulled all MCU residents that had transferred out of the PC and noted no additional issues were found.

Sustain: CSM / Admin will follow up with obtaining new prescreen for significant changes.

Licensee's Plan Completion Date: *09/08/2022*

Implemented (█ - 11/30/2022)

233b - Lock Manufacturer Statement

19. Requirements

2600.

233b - Lock Manufacturer Statement *(continued)*

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the magnetic locking devices for the secure dementia care unit, verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

POC Submission ***Accept [redacted] - 09/15/2022)***

Issues: No statement was provided for the mag lock mechanism from the manufacturer for fire alarm safety and operation.

Action: Immediately contacted Sage for requested information as attached.

Plan: Keep mag lock info and all MCU paperwork together in its own binder.

Sustain: All requested paperwork shall be kept in its own binder with access from Maintenance and Administrator.

Licensee's Plan Completion Date: *09/08/2022*

Implemented [redacted] - 11/28/2022)

233c Key Locking Devices

20. Requirements

2600.

233.c. If key locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism by the exterior door near room [redacted] and the exterior door near room [redacted] are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU).

POC Submission ***Accept ([redacted] 09/15/2022)***

Issue: Exterior mag lock code was not posted in a proper place.

Action: Immediately added the codes on top and on side of the actual mag locks instead of the sleeved paper that the previous ones were in and then was weathered.

Plan: Checked all locks for proper placement of codes.

Sustain: Monthly audit by Maintenance to ensure numbers are visible and placed within an acceptable distance to maglock every month.

Licensee's Plan Completion Date: *09/09/2022*

Implemented ([redacted] - 11/28/2022)

234a - Admission Support Plan

21. Requirements

2600.

234a - Admission Support Plan *(continued)*

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident's initial support plan was completed on [redacted]/22.

Resident #6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/22. However, the residents initial support plan was completed on [redacted]/22.

POC Submission ***Accept [redacted] - 09/15/2022)***

ssue: RASP was not updated as a significant change in a timely manner.

Plan: Pulled all MCU residents that had transferred out of the PC and noted no additional issues were found.

Sustain: CSM / Admin will follow up with obtaining new DME for significant changes.

Licensee's Plan Completion Date: *09/08/2022*

Implemented [redacted] - 11/30/2022)