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

April 11, 2023

[redacted]
COUNTRY MANOR PCH LP
111 ALTMEYER DRIVE
KITTANNING, PA, 16201

RE: COUNTRY MANOR
111 ALTMEYER DRIVE
KITTANNING, PA, 16201
LICENSE/COC#: 44629

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/30/2022, 12/01/2022, 12/12/2022 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: *COUNTRY MANOR* **License #**: *44629* **License Expiration**: *03/21/2023*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA 16201*

County: *ARMSTRONG* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *COUNTRY MANOR PCH LP*

Address: *111 ALTMEYER DRIVE, KITTANNING, PA, 16201*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *35* **Waking Staff**: *26*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/12/2022*

Inspection Dates and Department Representative

11/30/2022 - On-Site: [redacted]
12/01/2022 - On-Site:
12/12/2022 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *9* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *2* **Have Physical Disability**: *1*

Inspections / Reviews

11/30/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/15/2023*

Inspections / Reviews *(continued)*

02/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2023*

[redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/07/2023*

02/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/28/2023*

04/11/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/01/2023*

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

42c - Treatment of Residents

1. Requirements

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

Description of Violation

Multiple resident and staff interviews indicate staff person A regularly uses foul language in front of the residents. Residents express that this language makes them uncomfortable.

Plan of Correction ***Accept (JW - 02/03/2023)***

On 1-6-2023 Staff person A was re-trained by Administrator on this regulation, specifically addressing [redacted] foul language. [redacted] was made aware that further profanity could be reason for dismissal from [redacted] job. A training to be done by Administrator is also set for 1-17-2023 for all other Staff on this regulation. Residents were also reassured by Administrator that this regulation is being taken seriously and will be addressed.

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/05/2023)

42t - File Complaints

2. Requirements

2600.
42.t. A resident has the right to file complaints with any individual or agency and recommend changes in policies, home rules and services of the home without intimidation, retaliation or threat of discharge.

Description of Violation

Multiple resident interviews indicate residents are fearful of making complaints about the home because the home's staff will retaliate against them.

On [redacted], resident #1 complained about staff persons not administering his/her medication. Then, on 12/6/22, resident #1 received a 30-day discharge notice from the home. The staff person who issued the 30-day notice indicated in an interview that the issuance of the notice may serve to correct some of the resident's problematic behaviors.

Plan of Correction ***Accept (JW - 02/21/2023)***

A new poster with ombudsman contact info was requested and posted by Administrator on 1-6-2023 for all Residents to have access to. (Old one was a retired ombudsman). Residents have been talked to by the New Administrator re-assuring them that no retaliation will come from reporting issues. A training by Administrator is set for 1-17-2023 on this regulation. A list of 5 questions has been made by Executive Director to be used as a type of survey for Residents. The questions relate to how the Resident feels about various things in the home. Random interviews will be given to Residents by Administrator or Designee monthly using and keeping the forms to serve in addressing any areas of need. Documentation of training and surveys will be kept

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

51 - Criminal Background Check

3. Requirements

2600.

51 - Criminal Background Check *(continued)*

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

The home does not a have a criminal background check for staff person B who was hired on [redacted]

Plan of Correction ***Accept (JW - 02/21/2023)***

On the second day of inspection the Administrator was absent due to an emergency. Employee files were inspected that day. There is a binder with all verifying documents for each Employee. The designated person did not know about the binder. All supporting documents were inside to verify Background check for Staff Person B was completed on [redacted]*. Documentation kept. All background checks were reviewed by Executive Director on 1-11-2023. All important binders for the home were placed by Executive Director on a shelf directly behind Administrators desk. Large labels on each one to verify contents. A training to include where to find files for agencies requesting them will be done on 1-17-2023 by the Administrator.*

This violation is being disputed due to the criminal background check being present. Documentation available

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (JW - 02/21/2023)***

On the second day of inspection the Administrator was absent due to an emergency. Employee files were inspected that day. There is a binder with all verifying documents for each Employee. The designated person did not know about the binder. All supporting documents were inside, including high school diploma. All education requirements were reviewed by Executive Director on 1-11-2023. All important binders for the home were placed by Executive Director on a shelf directly behind Administrators desk. Large labels on each one to verify contents. A training to include where to find files for agencies requesting them will be done on 1-17-2023 by the Administrator.

This violation is being disputed due to the diploma being present. Documentation available

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

65a - FS Orientation 1st Day

5. Requirements

2600.

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

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

Staff person C, whose first day of work was [redacted], did not receive orientation on the following topics:

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.

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 extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Plan of Correction ***Accept (JW - 02/21/2023)***

On the second day of inspection the Administrator was absent due to an emergency. Employee files were inspected that day. There is a binder with all verifying documents for each Employee. The designated person did not know about the binder. All supporting documents were inside including start date of [redacted] with training also on [redacted] by Administrator. Documentation kept. All new Employee trainings were reviewed by Executive Director on 1-11-2023. All important binders for the home were placed by Executive Director on a shelf directly behind Administrators desk. Large labels on each one to verify contents. A training to include where to find files for agencies requesting them will be done on 1-17-2023 by the Administrator.

This violation is being disputed due to all required trainings being present. Also the start date listed is [redacted] not [redacted].Documentation available

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

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:

Description of Violation

Staff person C completed his/her 40th scheduled work hour during the week of [redacted]. However, this staff person did not complete training in the following topics:

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.

Plan of Correction ***Accept (JW - 02/21/2023)***

On the second day of inspection the Administrator was absent due to an emergency. Employee files were inspected that day. There is a binder with all verifying documents for each Employee. The designated person did not know about the binder. All supporting documents were inside to include first 40 hour training. Start date was [redacted]

65b - Rights/Abuse 40 Hours (continued)

and training was done on [redacted] and [redacted] by Administrator. All required trainings for Employees were reviewed by Executive Director on 1-11-2023. All important binders for the home were placed by Executive Director on a shelf directly behind Administrators desk. Large labels on each one to verify contents. A training to include where to find files for agencies requesting them will be done on 1-17-2023 by the Administrator.

This violation is being disputed due to all required trainings being present. Also the date of [redacted] should be [redacted]. Documentation available

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

81b - Resident Personal Equipment

7. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #2 has two half bed rails attached to his/her bed. The rails have openings of approximately 4 inches by 11 1/2 inches. The rail on the left side of the bed is partially covered with loose padding. The rail on the right side of the bed is uncovered. These openings pose an entrapment hazard.

Repeat Violation: 11/16/21, et al

Plan of Correction ***Accept (JW - 02/03/2023)***

On 1-9-2023 the right side bed rail for Resident #2 was removed by Administrator. The order states that the bed rails only need to be there if the resident wants them for assistance in getting out of bed. [redacted] uses the other one, and it was covered with lambswool on 1-9-2023 by Administrator. A Staff meeting with training by Administrator is scheduled for 1-17 @ 2pm. It Will include training that this Bed rail and all future bed rails will need to be covered, clean and intact at all times. administrator or designee will do weekly walk-throughs to check for compliance and safety. Documentation will be kept

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/05/2023)

85e - Trash Outside Home

8. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

The dumpster lid on the right side was open, and multiple black trash bags were protruding out of the dumpster.

Plan of Correction ***Accept (JW - 02/03/2023)***

On The day of inspection, the trash was pushed back into the dumpster by Administrator. The trash collector was due to come the next day. There was extra trash due to Christmas decorating. The staff had gotten rid of some old

85e - Trash Outside Home (continued)

things and it was more than the usual for the trash. There will be a staff meeting on 1-17-2023. The administrator will be doing training to include training on this regulation and the importance of keeping all trash contained to the dumpsters. The administrator or designee will do weekly walk-throughs to include checking the dumpsters. Documentation will be kept

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/10/2023)

95 - Furniture and Equipment

9. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident # 3's chest of drawers had no front panel on the drawers. The resident's clothes were spilling out of the drawers.

Plan of Correction ***Accept (JW - 02/03/2023)***

On 12-2-2022 The maintenance [redacted] fixed the dresser for resident number 3. Picture kept for documentation. Administrator did a complete walk-through of the building to check for other things that needed repair or cleaning. All items were taken care of or scheduled to be done by maintenance man. A training by Administrator will be done at the staff meeting on 1-17-23. administrator or designee will do a weekly walk-through of the facility to check for other things that need repaired or cleaned. Documentation will be kept

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/10/2023)

101j5 - Bedside Table/Shelf

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident #4's bed in bedroom [redacted]

Plan of Correction ***Accept (JW - 02/03/2023)***

Resident #4 has been refusing to have these items in room. Every time they are put in, [redacted]e sets them in the hall. Executive Director talked to Resident #4 on 1-10-2023 about a few options. Resident agreed to a very small shelf or stand and a very small light. Executive Director talked to Supervisor [redacted] on 1-11-2023 concerning what items are acceptable. A solution was found and items will be placed in the room by the Administrator by 1-17-2023. Administrator will be doing a training to include this regulation on 1-17-2023. Weekly walkthroughs of the Facility will be done by Administrator or Designee beginning the week of 1-16-2023. Documentation kept

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/10/2023)

101j7 - Lighting/Operable Lamp

11. 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 #4 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (JW - 02/03/2023)***

Resident #4 has been refusing to have these items in room. Every time they are put in, he sets them in the hall. Executive Director talked to Resident #4 on 1-10-2023 about a few options. Resident agreed to a very small shelf or stand and a very small light. Executive Director talked to Supervisor [redacted] on 1-11-2023 concerning what items are acceptable. A solution was found and items will be placed in the room by the Administrator by 1-17-2023. Administrator will be doing a training to include this regulation on 1-17-2023. Weekly walkthroughs of the Facility will be done by Administrator or Designee beginning the week of 1-16-2023. Documentation kept

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/10/2023)

103f - Refrigerator/Freezer Temps

12. Requirements

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

On 11/30/22, at 12:32 p.m., the temperature in the black freezer on left measured 48 degrees Fahrenheit.

On 11/30/22, at 12:33 p.m., the temperature in the black freezer on right measured 4 degrees Fahrenheit and at 2:35 p.m. it was 4 degrees Fahrenheit.

On 11/30/22, at 12:33 p.m., the temperature in the black refrigerator on right measured 46 degrees Fahrenheit and at 2:35 p.m. it was 42 degrees Fahrenheit.

Repeat Violation: 11/16/21 et al

Plan of Correction ***Accept (JW - 02/03/2023)***

On 12-1-2022 The administrator adjusted the settings on the refrigerator /freezer. Upon checking the temperatures the next day, they were within the limits that they should be. The administrator put a checklist on each refrigerator/ freezer for the cook to check each day and chart what the temperature is. Documentation kept. In addition the administrator will be training on this violation at the staff meeting on 1-17-2023

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/11/2023)

132a - Monthly Fire Drill

13. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of January 2022, March 2022, May 2022, June 2022, July 2022, August 2022, September 2022 and October 2022.

Plan of Correction ***Accept (JW - 02/21/2023)***

Under New Administration before the annual inspection, The Executive Director had an unannounced fire drill on 11-17-2023. The new Administrator and Executive Director will include the documentation of the fire drills on the large desktop calendar on Administrator desk each month. (Also on the designated form). The calendar has a reminder written to do a fire drill. The reminder is to be highlighted on completion of the drill. Monthly drills were also done in December and January (January sleeping hours) by Administrator and Executive Director. A training was done with Staff on January 12, 2023 by Executive Director to include the Fire evacuation process and regulation. Documentation kept.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/10/2023)

132b - Safety Inspection/Fire Drill

14. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill conducted by a fire safety expert was on 11/17/22. However, the previous inspection and drill was conducted on 4/30/21.

Plan of Correction ***Accept (JW - 02/03/2023)***

Under New Administration before the annual inspection, The Executive Director had an unannounced fire drill on 11-17-2023. This was done by the Executive Director and Fire Chief. The Fire Chief talked with the Executive Director about calling to set up the annual appointment a month or more ahead of time. It is marked on the Administrators calendar for October 1, 2023. The name and number of Chief is there for easy contact info. The inspections will be discussed at the quality management meeting to be sure they are done in a timely manner.

Licensee's Proposed Overall Completion Date: *01/13/2023*

Implemented (BG - 04/10/2023)

132e - Fire Drill Sleeping Hours

15. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 11/11/21 at 3:00 a.m.

Plan of Correction ***Accept (JW - 02/21/2023)***

The Executive Director and Administrator had an unannounced sleeping hours fire drill on This was done on 1-4-2023. The Administrator marked the large calendar on [redacted] desk for the month of the next sleeping hour drill. It

132e - Fire Drill Sleeping Hours (continued)

Will be done in July. The month requiring the sleeping hour drill has also been highlighted in advance by Administrator. The drills will be discussed at the quality management meeting to be sure they are done according to regulation. A training was done on January 12, 2023 by Executive Director to include this regulation and the sleeping hour procedure for fire drill. Documentation kept.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/10/2023)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/1/22, Clobetasol 0.05% cream, prescribed for resident #1, was in the home's medication cart; however, the medication was discontinued on 11/25/22.

Plan of Correction ***Accept (JW - 02/03/2023)***

On 12-1-2022 the cream for Resident #1 was disposed of by Administrator. Executive Director did a re-training with one of the daylight med-techs on auditing the med cart. This same med tech (designee) began monthly med cart audits of all residents with documentation on 12-14-2022. She will also do random checks of the med cart on the days she works. All med techs will be retrained on this regulation by the Administrator on 1-17-2023

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/10/2023)

187b - Date/Time of Medication Admin.

18. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1's November 2022 MAR is initialed by staff persons as administering Clobetasol 0.05% cream, apply to affected areas twice a day for 10 days from 11/15/22 until 11/25/22 on the following dates and times; however, the staff persons did not administer this medication to the resident:
On 11/15/22, at 9:30 p.m.
On 11/16/22, 11/17/22, 11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/22/22 at 8:00 a.m. and 9:30 p.m.

Plan of Correction ***Accept (JW - 02/21/2023)***

A MAR audit on Resident #1 was done by the Executive Director on 1-6-2023. All other MARS will be audited by Administrator and Designee by 2-8-2023 to check for any errors in documentation. Documentation kept. A training to be done with Med Techs on this regulation by Executive Director/Train the Trainer on 2-7-2023

This violation is being disputed due to the MAR indicating only one day without the cream and it was due to the Resident refusing. Proper documentation was present

Licensee's Proposed Overall Completion Date: *02/07/2023*

Implemented (BG - 04/10/2023)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #1 was prescribed Clobetasol 0.05% cream, apply to affected areas twice a day for 10 days from 11/15/22 until 11/25/22. However, the medication was not administered to the resident on 11/15/22, at 9:30 p.m., and on 11/16/22, 11/17/22, 11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/22/22 at 8:00 a.m. and 9:30 p.m.

Repeat Violation: 11/16/21 et al

Plan of Correction ***Accept (JW - 02/21/2023)***

A MAR audit on Resident #1 was done by the Executive Director on 1-6-2023. All other MARS will be audited by Administrator and Designee by 2-8-2023 to check for any errors in documentation. Documentation kept. A training is scheduled for 2-7-2023 by Executive Director/Train the Trainer to include this regulation

This violation is being disputed due to the MAR indicating only one day without the cream and it was due to the Resident refusing. Proper documentation was present

Licensee's Proposed Overall Completion Date: *02/07/2023*

Implemented (BG - 04/10/2023)

190a - Completion Medication Course

20. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D, who did not successfully complete the Department-approved medications administration course until 11/4/22, administered medications to residents to include the following:
On 11/2/22, at 8:30 a.m., and 2:00 p.m., Hydroxyzine HCL 50 mg to resident #1
On 11/3/22, at 8:30 a.m., 2:00 p.m., and 9:00 p.m., Hydroxyzine HCL 50 mg to resident #1

Plan of Correction ***Accept (JW - 02/21/2023)***

On the second day of inspection the Administrator was absent due to an emergency. Employee files were inspected that day. There is a binder with all verifying documents for each Employee. The designated person did not know about the binder. All supporting documents were inside to include med training with original certification date of 9-24-2020. All Med Tech trainings were reviewed by Executive Director on 1-11-2023. All important binders for the home were placed by Executive Director on a shelf directly behind Administrators desk. Large labels on each one to verify contents. A training to include where to find files for agencies requesting them will be done on 1-17-2023 by the Administrator.

This violation is being disputed due to the med tech having all needed trainings Documentation available

190a - Completion Medication Course *(continued)*

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (BG - 04/05/2023)

225c - Additional Assessment

21. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment, dated [redacted], indicates the resident has infrequent periods of iratability, minimal to no agitation and no issues with aggression. However, notes from the home's staff from 3/5/22 until 12/8/22 indicates numerous instances of threatening and verbally aggressive behavior toward residents and staff.

Plan of Correction ***Accept (JW - 02/03/2023)***

On [redacted] Executive Director did an addendum to Resident #1's RASP. The items updated were irritability, judgement, agitation and aggression. A form was implemented on 1-13-2023 by the Executive Director to indicate changes in Residents health or behavior. A training by Administrator is scheduled for 1-17-2023. This training will include training on this regulation and how all Staff are able to report on the form.

Licensee's Proposed Overall Completion Date: *01/17/2023*

Implemented (BG - 04/05/2023)