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

June 9, 2023

[redacted], AUTHORIZED OFFICER
READING AID II OPCO LLC
[redacted]

RE: MAIDENCREEK PLACE
105 DRIES ROAD
READING, PA, 19605
LICENSE/COC#: 22658

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/02/2023, 05/03/2023 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: *MAIDENCREEK PLACE* **License #**: *22658* **License Expiration**: *05/15/2024*

Address: *105 DRIES ROAD, READING, PA 19605*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *READING AID II OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/01/2004* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/03/2023*

Inspection Dates and Department Representative

05/02/2023 - On-Site: [redacted]

05/03/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *57*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

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

Have Mobility Need: *14* **Have Physical Disability**: *1*

Inspections / Reviews

05/02/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/20/2023*

05/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/07/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/05/2023*

Inspections / Reviews *(continued)*

06/09/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/07/2023*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home did not have the License Inspection Summary (LIS) report dated 7/6/22 posted in the home as required.

Plan of Correction ***Accept [redacted] - 05/30/2023)***

• On___5/4_, the Executive Director (ED) placed the homes License Inspection Summary (LIS) report dated 7/6/2022 in a binder labeled "Licensing Inspection Reports" in a conspicuous location within the home. (Exhibit-A1 Photo)
• On ___5/8__, the Regional Executive Director (RED) educated the ED and Administration Specialist on the requirements set within 2600.3c. (Exhibit –A2 In-service)
• Beginning __6/1___, the ED or designee will audit the contents of the "Licensing Inspection Reports" binder weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit A3– Audit tool)
• The 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 ____9/1___.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented ([redacted] - 06/09/2023)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The batteries in the carbon monoxide monitor located in the hallway near the gas fired water heaters were due to be replaced in December 2022 according to the label on the carbon monoxide monitor.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On __5/4___, the ED replaced the batteries in the carbon monoxide monitor in the hallway near the gas-fired water heaters. (Exhibit B1 – Photo)
• On __5/8___, the RED educated the ED on the requirements set within regulation 2600.18. (Exhibit B2– In-service)
• On _5/4___, the ED audited the home's carbon monoxide monitors, validating that batteries were replaced per schedule. No additional areas of non-compliance were noted. (Exhibit B3– Audit tool)
• Beginning __6/23____, the ED or designee will audit the homes carbon monoxide monitors, validating that batteries were changed as scheduled, monthly x 3 months. (Exhibit – B4 Audit tool)
• The 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 ____9/23___.

Licensee's Proposed Overall Completion Date: *09/23/2023*

18 Compliance With Laws *(continued)*

Implemented (- 06/09/2023)

60a Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The current census in the home is 57 residents; 14 of those residents have mobility needs. According to staff interviews, about 13 of those residents require a two person assist. The home does not have internal fire safe areas and all residents must be evacuated outdoors. On 4/29/23 and 4/30/23 there were only 2 staff persons scheduled on 3rd shift. Other days, the home regularly schedules 3 staff persons on 3rd shift. The home does not have adequate staff scheduled on 3rd shift to meet the needs of the residents in the event of an emergency.

Plan of Correction ***Accept (- 05/30/2023)***

• On __5/3__, the ED reviewed the direct-care staffing schedule for the succeeding 30 days to ensure three employees were scheduled on the 3rd shift. (Exhibit – C1Audit tool)
• On __5/8__, the RED educated the ED on the requirement set within regulation 2600.60a. (Exhibit C2– In-service)
• Beginning ___5/10__, the ED or designee will review the direct-care staffing schedule weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit C3– Audit tool)
• The 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 __7/26_____.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented (- 06/09/2023)

63a First Aid/CPR Training

4. 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 there was only 1 staff person with FA CPR training in the building on 3rd shift. The home's census at that time was 57.

Plan of Correction ***Accept - 05/30/2023)***

• On _5/4___, the ED reviewed the direct-care staffing schedule for the succeeding 30 days to ensure at least one staff person trained in CPR and first aid was scheduled for every 50 residents within the home. (Exhibit D1– Audit tool)
• On __6/7___, the ED facilitated a Staff CPR and First Aid recertification training course. (Exhibit D2- Training sign-in log) Scheduled June 7th
• On _5/8___, the RED educated the ED and Business Office Manager on the requirement set within regulation 2600.63a.(Exhibit D3
• Beginning__6/5 the ED__(designee will review the direct-care staffing schedule weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit D4– Audit tool)

63a - First Aid/CPR Training (continued)

• The 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 ___8/1___.

Licensee's Proposed Overall Completion Date: *08/01/2023*

Implemented [redacted] - 06/09/2023)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff person A was hired [redacted] as a direct care worker. Staff person A did not take the department's required direct care competency test until [redacted]

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On ___5/8__ the RED educated the ED/Business Office Manager on the requirements set within regulation 2600.65d (Exhibit E1– In-service)

• By ___5/18_, the Business Office Manager will audit current direct-care personnel files to ensure the Department-approved direct-care training course was completed and the associated competency assessment was passed. For instances indicating the course or competency were not taken and or passed, the staff member will be placed on administrative leave or removed from a direct-care position pending completion of the course and a passed competency assessment (Exhibit E2 – Audit tool)

• Beginning 6/2_____, the ED or designee will audit, if applicable, one newly hired or promoted direct-care personnel record weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate that the employee completed and passed the Department-approved direct-care training course before performing direct care. (Exhibit E3 – Audit tool)

• 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 ___7/28___.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented [redacted] - 06/09/2023)

103e - Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was a sealed bag of frozen cubed meat stored in the freezer that was not labeled with what the meat was and the date the bag was opened. There was also a small metal tray of diced meat stored in the cooler with no label to

103e - Left Overs (continued)

indicate the type of food and the date the leftover meat was placed in the cooler.

Plan of Correction ***Accept [redacted] - 05/30/2023)***

• On __5/2____, the ED removed and discarded the unlabeled and undated opened bag and tray of meat from the cooler and freezer.
• On ___5/2___, the ED audited the contents of the freezers, refrigerators, and pantry to ensure that food was stored and labeled in accordance with regulation 103.e. (Exhibit – F1 Audit tool)
• On ___5/8___, the ED educated the Chef on the requirements set within regulation 2600.103.e. (Exhibit F2– In-service)
• Beginning __5/8___, the Chef or designee will audit the home's freezers, refrigerators, and pantry weekly x 4, bi-weekly x 4, and monthly x 1 to ensure food is labeled and stored correctly. (Exhibit- F3 Audit tool)
• 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 ____7/3/23___.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented [redacted] - 06/09/2023)

132a - Monthly Fire Drill

7. Requirements

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

Description of Violation

The home did not conduct fire drills in the months of December 2022 and January 2023.

Plan of Correction ***Accept [redacted] - 05/30/2023)***

• On___5/9__, the Maintenance Technician conducted an unannounced fire drill. (Exhibit G1– drill log)
• On ___5/9__, the ED educated the Maintenance Technician on the requirements set within 2600.132.a. (Exhibit G2 – In-service)
• Beginning __6/9___, the ED or designee will audit the Fire Drill Log binder monthly x 3 months to validate sustained compliance. (Exhibit G3– Audit tool)
• The 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 ____8/30___.

Licensee's Proposed Overall Completion Date: *08/30/2023*

Implemented [redacted] - 06/09/2023)

132c - Fire Drill Records

8. Requirements

2600.

132c - Fire Drill Records *(continued)*

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 logs for fire drills held on [redacted] and [redacted] are incomplete because the logs do not record the number of residents in the home during the fire drill and the exits used during the fire drills.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On___5/9__, the Maintenance Technician conducted an unannounced fire drill. (Exhibit G1– drill log)

• On ___5/9__, the ED educated the Maintenance Technician on the requirements set within 2600.132.c. (Exhibit –G2 In-service)

• Beginning _6/9____, the ED or designee will audit the Fire Drill Log binder monthly x 3 months to validate sustained compliance. (Exhibit –H1 Audit tool)

• The 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 ___9/1____.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] - 06/09/2023)

182b - Prescription Medication

9. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B is a med tech. Annual practicums were completed for staff person A [redacted] and [redacted], more than 12 months apart.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On __1/2023___, the home's Train-the-Trainer retrained and certified Staff Person B before this violation. (Exhibit-I1 New Cert)

• On ___5/18__, the ED audited the currently employed medication technician's annual practicums, validating compliance. (Exhibit –I2 Audit tool)

• On ___01/2023__, the home's currently employed Medication Technicians were retrained and recertified by a Train-the-Trainer.

• Beginning __6/12___, the ED or designee will audit the currently employed medication technician's annual practicums monthly x 3 months to validate sustained compliance. (Exhibit-I3 Audit tool)

• The 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 _8/12_____.

182b - Prescription Medication (continued)

Licensee's Proposed Overall Completion Date: *08/12/2023*

Implemented [redacted] - 06/09/2023)

184a - Resident's Meds Labeled

10. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 has a PRN order for Olanzapine. The Medication administration record (MAR) indicates the medication is to be administered twice per day as needed. The pharmacy label on the medication indicates the medication is to be administered every 4 hours as needed. The pharmacy label does not list the correct physician's order.

Plan of Correction ***Accept [redacted] - 05/30/2023)***

• On ___5/8__, Order received to Discontinue Olanzapine. (Exhibit J1)

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• On ___5/18__, the Medication Technician audited the current resident medication orders and corresponding medication labels to validate that they match. (Exhibit K2– Audit tool)

• Beginning ___6/5___, the LPN or designee will audit three residents' medication orders weekly x 4 weeks, bi-weekly x 4 weeks, and weekly x 4 weeks to validate sustained compliance. (Exhibit J2– Audit tool

• The 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 ___9/1____.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented [redacted] - 06/09/2023)

185a - Implement Storage Procedures

11. 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 #1 has a PRN order for [redacted]. The medication was not available in the medication cart to be administered as needed.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On ____5/2__, the ED found Resident #1's prescribed Albuterol from the pharmacy. K1

• On ___5/18___, the ___Medication Technician __ audited the PRN medications of current residents to validate their presence within the home. (Exhibit -K2 Audit tool)

• On _____5/9__, the RED educated the ED on the requirements set within 2600.185.a. (Exhibit-K3 Audit tool)

• __5/31__The ED or designee will audit the PRN medications of 3 residents weekly x 4 weeks, bi-weekly x 4 weeks,

185a Implement Storage Procedures (continued)

and monthly to validate sustained compliance. (Exhibit K4 Audit tool)

• The 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 9/30 .

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 06/09/2023)

187a - Medication Record

12. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

8. Frequency of administration.
9. Administration times.
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 has an order for [redacted] 1 tablet two times daily. The home did not have documentation of this medication's administration for the month of April 2023.

Resident #2 has an order for [redacted], 1 tablet two times daily. On the following dates the med tech did not initial that the medication was administered: [redacted]

Resident #3 has an order for [redacted] drops, 1 drop in each eye two times daily. The med tech did not initial that the medication was administered on [redacted]

Plan of Correction ***Accept (- 05/30/2023)***

• On 5/3 , the LPN evaluated residents #2, #3, and #4; no ill effects were noted. In addition, the LPN notified their primary care physician, and no new orders were L1 received.

• On 5/3 , the ED located Resident #1 MAR which was transcribed for April L2

• .

• On 5/3 , the Medication Technician notified Resident #2, their physician, and their responsible party of the missed Furosemide administrations.

• On 5/3 , the Medication Technician notified Resident #3, their physician, and their responsible party of the missed Timoptic drops administrations.

• On 5/4 , the ED completed and submitted a Department of Human Services (DHS) reportable incident report in reference to Resident #1, #2, and #3's missed L1 administrations.

• On 5/8 , the ED in serviced currently employed LPNs and Medication Technicians on the requirements set within 2600. 187.a. (Exhibit In service)

• On 5/10 , the ED audited the current month's MAR to self identify additional documentation omissions. (Exhibit Audit tool)

• Beginning 5/30 , the ED or designee will audit the current month's MAR, weekly x 4 weeks, bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance (Exhibit L5 Audit tool)

• The 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.

187a - Medication Record (continued)

• Completion date__8/31____.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [redacted] - 06/09/2023)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident #2 has an order for [redacted], [redacted] units to be administered before breakfast but held if the blood sugar (BS) is less than 100. On [redacted] the BS reading was recorded as [redacted] on the MAR for the breakfast reading but there was no reading in the resident's glucometer for this date and time. Also, on [redacted] there was no BS reading in the glucometer before breakfast.
Resident #3 has an order for [redacted], hold for systolic blood pressure (SBP) less than 100. From [redacted] the home did not check the resident's SBP prior to administering the medication.
Resident #4 has an order for [redacted], to be administered 3 times daily on a sliding scale.
On [redacted] there was only a morning blood sugar reading found in the resident's glucometer. The lunch time and dinner time documented readings and insulin administration on this date could not be verified as accurate administrations.
On [redacted] there is a blood sugar reading of [redacted] at lunch time that was not found in the resident's glucometer. [redacted] units of insulin were administered.
On [redacted] the dinner time blood sugar reading was documented on the MAR as [redacted] with [redacted] of insulin administered. The correct blood sugar reading found in the glucometer for this date and time was [redacted] requiring [redacted] of [redacted]
On [redacted] the dinner time blood sugar reading was recorded as [redacted] on the MAR. No blood sugar reading was found in the resident's glucometer for this date and time.

Plan of Correction ***Accept ([redacted] - 05/30/2023)***

• On ____5/3, the LPN evaluated residents #2, #3, and #4; no ill effects were noted. In addition, the LPN notified their primary care physician, and no new orders were L1,M1 received.
• On __5/18__, the CSM audited the MARs for the preceding 30 days to ensure no additional instances were identified where the home did not follow the prescriber's directions. No other incidents were identified. M2
• On __5/8___, the ED, also a licensed nurse, educated currently employed licensed nurses and medication technicians on the requirements set within regulation 2600.187.d (Exhibit L3– In-service)
• Beginning __6/8___, the ED or designee will audit three residents' glucometer results and the corresponding blood glucose recordings on the MAR weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 month to validate sustained compliance (Exhibit M3– Audit Tool)
• The 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__9/30___.

Licensee's Proposed Overall Completion Date: 09/30/2023

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

Implemented (- 06/09/2023)

227a Support Plan 30 Days

14. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

The support plan dated for resident #5 is incomplete because the bladder and bowel management sections on page 3 were not completed to indicate the resident's need and the plan to meet these needs.

Plan of Correction ***Accept (- 05/30/2023)***

• On ____5/2_, the ED updated resident #6's Resident Assessment and Support Plan (RASP) to reflect the resident's bowel and bladder management needs. (Exhibit – N1 Updated RASP)
• On __5/17___, the RED educated the ED on the requirements set within regulations 2600.227.a. (Exhibit –N3 In-service)
• On _5/18___, the ED audited current resident RASPs to validate that each section pertaining to bowel and bladder management was thoroughly completed. For additional omissions identified, the ED updated the RASP accordingly. (Exhibit-N2 Audit tools)
• Beginning __5/30___, the ED or designee will audit 3 current residents' RASPs, weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance (Exhibit- N4 Audit tool)
• The 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__8/31_____.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented (- 06/09/2023)

227d Support Plan Medical/Dental

15. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #6 has a physician's order for a pureed diet. Dietary staff interviews confirmed the resident is provided a pureed diet for all meals. The support plan dated 5/14/22 was not updated to reflect that the resident requires a pureed diet.

Plan of Correction ***Accept - 05/30/2023)***

• On ____ _, the ED updated resident #6's RASP to reflect the resident's ordered pureed diet. (Exhibit O1– Updated RASP)

227d - Support Plan Medical/Dental (continued)

• On __5/17___, the RED educated the ED on the requirements set within regulations 2600.227.d. (Exhibit –N3 In-service)
• On _5/18___, the ED audited current resident RASPs to validate the correct diets were accurately recorded. For additional instances of incorrect diets, the ED updated the RASP accordingly. (Exhibit-O3 Audit tools)
• Beginning __5/30___, the ED or designee will audit three current residents' RASPs, weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance (Exhibit-O4 Audit tool)
• The 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_____8/31__.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented ([redacted] - 06/09/2023)