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

February 9, 2024

[redacted], EXECUTIVE DIRECTOR
EMERITUS CORPORATION
[redacted]

RE: BROOKDALE GRANDON FARMS
1100 GRANDON WAY
MECHANICSBURG, PA, 17055
LICENSE/COC#: 31612

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/17/2024, 01/18/2024 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: *BROOKDALE GRANDON FARMS* **License #**: *31612* **License Expiration**: *01/17/2025*

Address: *1100 GRANDON WAY, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *EMERITUS CORPORATION*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/15/2005* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *73* **Waking Staff**: *55*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *01/18/2024*

Inspection Dates and Department Representative

01/17/2024 - On-Site: [redacted]

01/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *50*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Clare Bridge* **Capacity**: *30* **Residents Served**: *21*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *50*

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

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

01/17/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/02/2024*

02/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/12/2024*

Inspections / Reviews *(continued)*

02/09/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/08/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at approximately [redacted], a physical altercation occurred between Resident 4 and Resident 5. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 02/02/2024)***

1/18/2024- Appropriate clinical and management team were retrained by the Executive Director (ED) on the community policy regarding suspected abuse and timely notification to the local area on aging. A community retraining will be completed by OAPSA representative, [redacted], MSW Executive from Aging and Community Services, Protective Services Supervisor, Carlisle, Pennsylvania regarding Mandated Reporting allegations of abuse/neglect on February 6th, 2024 at 2:30pm.

Director immediately trained all staff (nursing, dietary, housekeeping and managers) on resident to resident abuse and that all abuse needs to be reported to Area of Aging on 01/19/2024. Executive Director contacted the local Area of Aging and they are coming to do a mandatory in service on Resident abuse on February 6th @2:30pm. Going forward Executive Director will report all abuse to the Area of Aging. Ongoing- To assist with compliance, the ED will review any potential incidents as they occur for 1 month starting January 15,2024 through February 15th, 2024. Monthly reviews will then be completed thereafter by the ED to verify compliance and to determine if any further action is warranted starting February 15th, 2024.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented ([redacted] - 02/09/2024)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] at approximately [redacted], a physical altercation occurred between Resident 4 and Resident 5. The home did not report this incident to the department until [redacted]

Plan of Correction ***Accept ([redacted] - 02/02/2024)***

1/19/2024 Direct Care Clinical and Management staff were retrained by the ED on the Community Policy regarding suspected abuse and timely notification to the Department of Humans Service Regional Office.

A community retraining will be completed by OAPSA representative, [redacted], MSW Executive from Aging and Community Services, Protective Services Supervisor, Carlisle, Pennsylvania regarding Mandated Reporting allegations of abuse/neglect on February 6th, 2024 at 2:30pm.

Ongoing- To assist with compliance, the ED or designee will review any potential incidents as they occur daily for one (1) month starting on January 15th,2024 through February 15th, 2024. Following, reviews by the ED will occur weekly for (1) additional month to verify compliance starting February 15th, 2024 and ending March 15th, 2024. Monthly reviews will then be completed thereafter by the ED or designee too verify compliance and to determine if

16c Written Incident Report (continued)

any further action is warranted starting March 15th, 2024.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented (- 02/09/2024)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] at approximately [redacted], Staff Member A and Staff Member B witnessed an altercation between Resident 1 and Resident 2. Resident 2 grabbed Resident 1's arm while attempting to enter his/her room and would not let go. Residents were separated by Staff Members A and B. Resident 1 sustained a bruise on his/her left arm as a result of the incident.

On [redacted] at approximately 4pm, Resident 4 grabbed Resident 5 by the arm and pulled him/her. Resident 5 sustained a bruise on his/her arm as a result of the incident.

Plan of Correction ***Accept (- 02/02/2024)***

1/19/2024 Direct care clinical and management staff were retrained by the ED on the community policy regarding treating residents with dignity and respect as documented in the Resident's Rights.
A community retraining will be completed by OAPSA representative, [redacted], MSW Executive from Aging and Community Services, Protective Services Supervisor, Carlisle, Pennsylvania regarding Mandated Reporting allegations of abuse/neglect on February 6th, 2024 at 2:30pm.
Ongoing The ED, clinical and management team will continue to promote resident dignity at orientation, dementia training, annual trainings, during staff meetings and whenever indicated.
Ongoing To assist with compliance, The ED or designee will review any potential incidents as they occur daily for (1) month starting January 15th, 2024 through February 15th, 2024. Following, reviews by the ED or designee will occur weekly for (1) additional moth to verify compliance starting February 15th, 2024 and ending March 15th, 2024 to very compliance and to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented - 02/09/2024)

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 1/17/24, an Alexa device was playing music in the main common area of the home. However, written notification for the use of this voice controlled device was not posted.

Plan of Correction ***Accept (- 02/02/2024)***

1/17/2024 The Activities Director as soon as identified posted a sign near the Alexis Device indicating it was in

42s - Privacy (continued)

operation. A review was completed of any other recording devices in common areas in the community and they were found in compliance.
Going forward the Activities Director or Executive Director will do weekly audits for 2 months starting 1/15/2024 to verify that the sign is posted if the Alexa is in use until 3/15/2024.
1/19/2024- Management staff were retrained by the ED on the community policy regarding resident's rights to privacy.
Monthly reviews will be then be completed thereafter by the ED or designee to verify compliance and to determine if any further action is warranted starting 3/15/2024.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Implemented [redacted] - 02/09/2024)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted] of [redacted] Toothpaste, with a manufacture's label indicating "If accidently swallowed get medication help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room 307 of the Secured Dementia Care Unit (SDCU). These residents have been assessed incapable of recognizing and using poisons safely.

Repeated Violation-2/22/23, et al

Plan of Correction ***Accept ([redacted] - 02/02/2024)***

1/18/2024-The small tube of toothpaste in room 307 was removed by the Health Wellness Coordinator as soon as it was identified as accessible in the SDCU.
1/19/2024-ED retrained appropriate clinical and management staff on the community policy regarding storage of poisonous materials, keeping them locked and inaccessible to resident's.
1/24/2024- SDCU Program Director completed an audit of resident's rooms in SDCU for poisonous materials. No other poisonous materials were identified unsecured and the SDCU was found in compliance.
1/30/2024- SDCU Program Director or designee will perform weekly audits for 2 months to verify poisonous materials are secured according to community policy ending 3/30/2024. Reviews will then continue monthly thereafter starting 3/31/2024.
Ongoing- The ED will review the results of the audits to determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

85d - Trash Receptacles

6. Requirements

2600.

85d - Trash Receptacles *(continued)*

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 1/17/24, there was a full, uncovered, unattended trash can in the main dining room.

Plan of Correction ***Accept ([redacted] - 02/02/2024)***

1/17/2024- Dining staff immediately covered the trash can in the dining area on.
1/17/2024- All other kitchen and dining trash cans were audited by the ED to verify lids were present, functioning and in place. No other trash cans were found to be out of compliance.
1/19/2024- Executive Director trained all dining staff and other appropriate clinical staff regarding the community policy on covering trash cans in kitchens and dining area.
1/29/2024- Dining Director or designee will perform weekly audits to verify trash cans are covered with lids starting on 1/31/2024 for 1 month until 2/29/2024
Ongoing- Ed will review audit results to determine if any further action is warranted and ED or designee will perform random audits of dining/kitchen trash cans to verify continued compliance.

Licensee's Proposed Overall Completion Date: *02/29/2024*

Implemented ([redacted] - 02/09/2024)

95 - Furniture and Equipment

7. Requirements

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

Description of Violation

On 1/18/24, an exposed gas pipe was observed protruding from underneath the Ptech unit in room 304. This poses as a potential tripping hazard.

Plan of Correction ***Accept ([redacted] - 02/02/2024)***

1/18/2024 Maintenance technician immediately secured the gas pipe on the PTECH unit in room 304.
1/19/2024- ED retrained appropriate clinical and maintenance staff on the community policy regarding furniture and equipment not representing a tripping hazard.
1/23/2024- The Maintenance Director did an audit of the Ptech units in the SCDU rooms and verified units were secured and not a tripping hazard. Other units were found in compliance.
1/31/2024- Ongoing. The Maintenance Director or designee will perform weekly audits on the SCDU rooms to verify the gas pipes are secured for 2 months until 03/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 02/09/2024)

103f - Refrigerator/Freezer Temps

8. 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 1/18/24 at 10am, the temperature in the walk-in freezer was 10 degrees Fahrenheit, and at 12:33pm

103f - Refrigerator/Freezer Temps (continued)

it was 9 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 02/02/2024)***

1/18/2024- Maintenance Director cleaned out the fan in the walk in freezer
1/19/2024-Smart Care Equipment Solutions recalibrated the thermometer and cleaned out the coil. The temperature was then recorded at -12 degrees.
1/19/2024- The Executive Director retrained the appropriate kitchen/dining staff on the community policy regarding monitoring freezer temperature's.
2/30/2024- Maintenance Director, Dining Director or designee will perform temperature audits twice daily for 2 months, at the beginning of the shift and at the end of the shift and record on temperature log ongoing starting on 1/30/2024 through 3/30/2024 then daily thereafter ongoing starting 3/31/2024.
Ongoing- ED will review the audits to determine if any further action is warranted and perform random audits if indicated.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 1/17/24, two tubs of ice cream were observed to be uncovered in the freezer located in the bistro.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1/18/2024- Dining staff member secured the lids on the ice cream containers in the bistro freezer.
1/19/2024- Executive Director retrained the appropriate clinical staff regarding the community policy on storing food in closed or sealed containers.
1/31/2024- Dining director or designee will perform weekly audits of the ice cream stored in the bistro to verify ice cream is maintained in sealed containers for 2 months until 3/31/2024.
Ongoing- ED will review the audits of ice cream storage in the bistro to verify continued compliance.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 02/09/2024)

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 were not reviewed and submitted to the local emergency management agency (EMA) in 2023.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1/19/2024- Ed retrained the appropriate maintenance and management staff on the community policy regarding annual emergency management plan approval by the local fire authority.

107d - Procedure Emergency Management Agency Submission (continued)

An annual reminder was noted in the electronic maintenance tracker TELS to have the plan approved by the local fire authority at the township.
The community's written emergency management plan was submitted to [redacted], Township Fire Department Hampton Fire Department on January 19th, 2024 by the Executive Director.
Ongoing- ED, Maintenance Director or designee will review the results of the annual review of the emergency management agency yo determine if any further action is warranted on receipt of the document.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (GR - 02/09/2024)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 3's medical evaluation (DME), dated 8/8/22, did not include the medication regimen or the medical professional's name, signature, date and license number.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1/17/2024- Executive Director faxed DME to physician's office for completion to include the signature, date and license number. The completed form when received for resident #3 will be placed in the medical record.
1/19/2024- Executive Director retrained the appropriate clinical staff on the community policy regarding required information. Other DME's were noted to be in compliance.
1/19/2024- Audit completed on recent admissions by HCC and clinical leader's of DME's for the last 6 month regarding the required information Other DME's were noted to be in compliance.
Ongoing- starting 1/30/2024- The Health and Wellness Director (HWD), Health Wellness Coordinator (HWC) or designee will review each DME on submission prior to admission to verify areas are completed according t the community policy for 2 months ending 3/30/2024.
To assist with ongoing compliance, the Health and Wellness Director or designee will review the results of these audits to verify compliance and determine if any further action is warranted.
Ongoing starting 1/31/202- ED or designee will complete random audits to review compliance,

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

141b1 - Annual Medical Evaluation

12. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 2's most recent medical evaluation (DME) was completed on [redacted]. The resident's previous DME was completed on [redacted].

Repeated Violation-2/22/23, et al

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1/19/2024- Executive Director retrained appropriate clinical staff on the community policy regarding availability of prior DME's either in the medical record or available in a reduced chart.
1/19/2024- Audit completed on prior DME's availability by HWC and clinical leaders in the medical record or in reduced record. Other medical evaluations were noted to be in compliance.
Ongoing starting 1/30/2024- The HWD, HWC or designee will verify prior DME retention when the DME's are received for 2 months ending 3/30/2024.
To assist ongoing compliance, the Health and Wellness Director or designee will review the results of these audits to verify compliance and determine if any further action is warranted.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 02/09/2024)

162c - Menus Posted

13. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 1/7-1/20/24 was posted. However, the menu for the following week was not posted.

Plan of Correction ***Accept ([redacted] - 02/05/2024)***

1/17/2024- The Menu for the following week was posted by the Executive Director.
1/19/204- Executive Director retrained the appropriate dining staff on the community policy regarding the posting of the menus one week in advance.
1/31/2024- The dining Director or designee will perform weekly audits to verify menus are posted according to the community policy for 2 months until 3/31/2024.
Ongoing- 3/31/2024- ED or designee will complete random audits to review compliance.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 02/09/2024)

185a - Implement Storage Procedures

14. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 is prescribed [redacted]) spray as needed. On [redacted] these medications were not available in the home.

Resident 3 is prescribed [redacted] topical powder as needed. On 1/18/24 these medications were not available in the home.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1/19/2024- Executive Director retrained the appropriate clinical staff on the community policy regarding availability of medications.
1/23/2024- Executive Director contacted the physician and the need for these medications was reviewed. The physician discontinued resident#1's "as needed" medications as these medications were no longer needed.
1/23/2024 Executive Director faxed resident #3's physician to have meds reviewed in house for non use. The Physician discontinued these medications for resident #3 as these are no longer needed.
1/26/2024- HWC or designee will perform weekly med cart audits for 3 months to verify medications are available fir the resident's medications as ordered by the physician ending 4/26/2024 then monthly thereafter.
HWD or designee will review the results of the audits to determine if any further action is warranted. Random audits will be performed as indicated.

Licensee's Proposed Overall Completion Date: *04/26/2024*

Implemented [redacted] - 02/09/2024)

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

On [redacted] at approximately [redacted] Resident 3's glucometer was not calibrated with the correct date and time. Date observed in glucometer was 5/28 and time was 12:30pm.

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1/18/2024-Executive Director recalibrated the glucometer to the correct date and time. An audit was completed for other glucometers and dates were verified to be correct.
1/19/2024- The executive Director retrained the appropriate clinical staff on the community policy regarding the use of medical equipment/ glucometers and the importance of accurate calibration of the date and time.
Ongoing starting 1/30/2024- A glucometer audit for was implemented. Glucometers will be audited twice weekly by the Health and Wellness Director or Health Care Coordinator for 2 months to verify compliance until 3/30/2024 and perform weekly thereafter ending 3/30/204.
1/30/2024- To assist with ongoing compliance, the Health and Wellness Director or designee, will review audit results for the next 2 months to verify compliance until 3/30/2024 and perform random audits as indicated.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident 1 is prescribed [redacted]) daily. However, this medication was not administered to Resident 1 on [redacted] because the medication was not available in the home.

Resident 1 is prescribed [redacted]) three times a day. However, this medication was not administered to Resident 1 on [redacted] because the medication was not available in the home.

Resident 3 is prescribed [redacted]. However, these medications were not administered to Resident 3 from [redacted] and from [redacted] because the medications were not available in the home.

Repeated Violation-2/22/23, et al

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1/17/2024- Executive Director notified the pharmacy to have the medications that weren't available delivered on 1/17/2024.
1/19/2024- The Executive Director retrained the appropriate clinical staff and medication technicians on the process of reordering medications.
1/19/2024- A review was completed by the HWC and Medication Technicians of the "as needed medications" compared the residents' emar and the remainder were found in compliance.
1/31/2024- AN "as needed" medications audit form will be implemented to review and track availability, matching the documentation with the EMAR. This will be completed by the HWD, HWC or designee for 2 months ending on March 31st 2024.
1/31/2024- To assist with ongoing compliance, this process will be reviewed weekly by the Health and Wellness Director or designee and then monthly starting on March 31st, 2024. Random audits will occur as indicated.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 02/09/2024)

231c Preadmission Screening

17. 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 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, Resident 1's written cognitive preadmission screening was completed on [redacted]

Repeated Violation-2/22/23, et al

231c - Preadmission Screening *(continued)*

Plan of Correction ***Accept [redacted] - 02/05/2024)***

1/19/2024- The Executive Director retrained the appropriate clinical staff on the community policy regarding cognitive prescreen completion prior to transfer to the SDCU.
1/19/2024- Executive Director and HWC completed an audit of the prescreen for completion for those residents transferred from the personal Care unit to the SDCU on 1/19/2024. Other prescreens were found in compliance with the community policy.
1/30/2024- HWD, HWC or designee will review Prescreen forms for 3 months on those residents transferred from the Personal Care unit to the SDCU from 1/30/2024-3/30/2024.
On going thereafter- HWD or designee will review the audit results to determine if any further action is warranted and perform random audits to verify continued compliance starting on 3/30/2024. To assist with on going compliance, this process will be audited weekly by the Health and wellness Director or designee monthly thereafter starting on March 31st, 2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 02/09/2024)