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

May 31, 2024

[redacted] COO
CARE HSL HERITAGE HILL OPCO LLC
[redacted]

RE: HERITAGE HILL SENIOR COMMUNITY
800 SIXTH STREET
WEATHERLY, PA, 18255
LICENSE/COC#: 22512

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/24/2024, 04/25/2024 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: *HERITAGE HILL SENIOR COMMUNITY* **License #**: *22512* **License Expiration**: *04/18/2025*

Address: *800 SIXTH STREET, WEATHERLY, PA 18255*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL HERITAGE HILL OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/05/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *101* **Waking Staff**: *76*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/25/2024*

Inspection Dates and Department Representative

04/24/2024 - On-Site: [redacted]

04/25/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *78*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *42* **Residents Served**: *22*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*

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

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

Inspections / Reviews

04/24/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/13/2024*

Inspections / Reviews *(continued)*

05/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/24/2024*

05/28/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/02/2024*

05/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2024*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The home developed an Appendix A to their Resident Agreement titled Request for In Room Video Monitoring which also outlines the use of voice controlled electronic devices in the home. The Appendix "A" Agreement was noted in the records of the following residents and were not signed or dated by the resident or their responsible party: Residents #1, #2, #3, #4, #5, and #6.

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Actions: The Clinical Care Coordinator obtained signatures for Responsible Parties for Residents #1, #2, #3, #4, #5, and #6 , completed 5/8/2024.

Additional Corrective Actions: The Executive Director is reviewing all resident records to ensure the Resident Agreements are in place and signed. A 30 Day Record Audit will be utilized. This will be completed by 5/31/2024.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited by the Executive Director each month, with findings reviewed at the Quarterly Quality Assurance Meetings, beginning in June 2024.

Licensee's Proposed Overall Completion Date: *05/31/2024*

Implemented (- 05/28/2024)

29a SOPb4 - Hospice Care: Inform Non-Participating

2. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
4. During a fire drill, the one designated person at the home who has knowledge in advance of the fire drill is to immediately upon setting off the fire alarm to begin the fire drill, go to the room of the resident who meets the conditions of paragraphs (1)—(3), and notify the affected resident and any staff person who attempts to evacuate the resident, that this is a fire drill and the resident is not to be evacuated.

Description of Violation

Resident #7 was not evacuated during fire drills that were conducted from December 2023 through April 2024 due to actively dying as certified by the resident's physician. Staff person A, who conducts the fire drills, did not immediately go to the resident's room to notify staff that a fire drill was being conducted and the resident should not be evacuated. Repeated violation 7/12/23, et al.

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Actions: The violation can not be corrected for Resident #7, for fire drills held in December 2023 through April 2024, as those fire drills have already passed.

Additional Corrective Actions: On 4/30/2024, the Executive Director, Maintenance Director, and Maintenance Assistant reviewed RCG SOP 2600.29.a.b. The Heritage Hill Fire Safety Plan will be updated by 5/31/2024, to include guidance on RCG SOP 2600.29.a.b. The Executive Director and Maintenance Director will review the list of any

29a SOPb4 - Hospice Care: Inform Non-Participating (continued)

actively dying residents prior to fire drills to ensure the Maintenance Director is prepared to implement all required elements if a resident is not evacuated.

Ongoing Quality Assurance Actions: The Executive Director will complete a monthly audit for of Fire Drill logs to ensure compliance with RCG SOP 2600.29.a.b. This will be reviewed as part of the Quarterly QA Meetings, beginning no later than June 2024.

Licensee's Proposed Overall Completion Date: *05/31/2024*

Implemented (- 05/28/2024)

42c - Treatment of Residents

3. Requirements

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

Description of Violation

On [redacted] Staff person B heard Staff person C scream loudly at Resident #8 from the opposite end of the first-floor hallway saying, "I don't know why you just won't cooperate and pick up your feet!". Staff person B then heard Resident #8 repeatedly scream, "Get away from me!". Resident #8 was not treated with dignity and respect by staff person C. Repeated violation 7/12/23, et al.

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Actions: Staff Member C was immediately suspended by the Executive Director on [redacted] following the incident to allow for investigation. Staff Member C was subsequently terminated on [redacted] by the Executive Director.

Additional Corrective Actions: All staff will complete training on Dignity and Respect no later than 5/31/2024. During the May 2024 All Staff Meeting on 5/14/2024, Resident Rights and Reporting Procedures will be reviewed by the Executive Director with all staff members.

Ongoing Quality Assurance Actions: The Resident Life Director will review Resident Rights with residents during monthly Resident Council Meetings and report any concerns to the Executive Director. Findings and trends will be reviewed as part of the Quarterly QA Meetings, beginning June 2024

Licensee's Proposed Overall Completion Date: *05/31/2024*

Implemented (- 05/28/2024)

64c - Annual Training

4. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The home's administrator, staff person [redacted], did not complete at least 12 hours of their required annual administrator

64c - Annual Training (continued)

training hours in person during the 2023-24 training year.

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Actions: During the inspection on 4/25/2024 the Executive Director reviewed RCG Requirement 2600.64.c with the lead inspector.

Additional Corrective Actions: Staff Person will complete the required 12 in-person training hours for 2023 in addition to the 12 hours for 2024, by December 2024, as required by regulation, by December 31, 2024.

Ongoing Quality Assurance Actions: The Executive Director will complete a quarterly audit of all training completed to ensure compliance with in-person training hour requirements. This will be reviewed as part of the Quarterly QA Meetings, beginning June 2024.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 05/31/2024)

65b - Rights/Abuse 40 Hours

5. 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:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person E, who regularly volunteers in the home, did not have the required trainings on the emergency medical plan and reportable incidents within 40 hours of their start date.

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Actions: Staff Person E is a volunteer and will complete training on Emergency Medical Plan and Reporting of Reportable Incidents prior to continuing to volunteer in the community.

Additional Corrective Actions: The Business Office Director was retrained by Executive Director on RCG 2600.65.b on 5/7/2024. The Volunteer Orientation Program was updated on 5/8/2024 to ensure compliance with required training topics.

Ongoing Quality Assurance Actions: The Business Office Director will complete a monthly audit of Volunteer Training Records to ensure required training topics are reviewed. This will be reviewed as part of the Quarterly QA Meetings, beginning June 2024.

Licensee's Proposed Overall Completion Date: *05/13/2024*

Implemented (- 05/28/2024)

96c - First Aid Accessible

6. Requirements

96c - First Aid Accessible *(continued)*

2600.
96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

The home did not have a first aid kit that was accessible to all staff. The home had a first aid kit in the locked medication room; not all staff have keys to unlock this room. The home also had a first aid kit in the kitchen, however the first aid kit was bolted to the wall and could not be removed in the event of an emergency.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Actions: On 4/29/2024, the Maintenance Director removed the First Aid Kit from the kitchen wall and placed it in an accessible location in the kitchen.

Additional Corrective Actions: Additional First Aid Kits were ordered on 5/7/2024. There will now be 4 First Aid Kits: located in the utility closet by room 11; in the kitchen; the Memory Care Dining Room; and the community van. During the All Staff Meeting to be held on 5/14/2024, the location and use of First Aid Kits will be reviewed with all staff by the Executive Director.

Ongoing Quality Assurance Actions: Beginning 5/8/2024 The Maintenace Director will monitor First Aid Kit accessibility as part of the Daily Maintenance Walkthrough. This will be reviewed as part of the Quarterly QA Meetings, beginning June 2024.

Licensee's Proposed Overall Completion Date: *05/14/2024*

Implemented ([redacted] - 05/28/2024)

132d - Evacuation

7. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

According to the home's fire safety inspection letter dated 8/29/23 the home does not have fire safe areas and the maximum safe evacuation time is noted as 12 minutes and 40 seconds. On 4/23/24 the fire drill conducted at 6:05am had an evacuation time of 12 minutes and 55 seconds. On 10/27/23 the fire drill conducted at 6:05am had an evacuation time of 14 minutes and 5 seconds. Repeated violation 7/12/23, et al.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Actions: The violation could not be immediately corrected since the April 2024 Fire Drill had since been completed prior to the time of the inspection.

Additional Corrective Actions: During the inspection and discussions between the DHS Inspector, the Executive Director, and the Maintenance Director, it was determined that the home's maximum safe evacuation time has been incorrectly determined. Historically, the time was measured by the Weatherly Fire Chief as a measure of how quickly staff were able to evacuate all residents in the home, not accounting for the construction of the building. On 4/26/2024, the Weatherly Fire Chief was contacted to schedule a re-evaluation of the maximum safe evacuation time with consideration for building construction and conditions. If needed, the Executive Director will consult a

132d - Evacuation (continued)

DHS approved fire safety expert, to assist the Weatherly Fire Chief in developing an appropriate measure of the home's maximum safe evacuation time.

On 4/30/2024, the Executive Director reviewed RCG SOP 2600.132.d. with the Maintenance Director and Maintenance Assistant.

Ongoing Quality Assurance Actions: The Maintenance Director maintains a log of all fire drill evacuation times. The Executive Director will complete a monthly audit of Fire Drill logs to ensure compliance with RCG SOP 2600.132.d. This will be reviewed as part of the Quarterly QA Meetings, beginning no later than June 2024.

Licensee's Proposed Overall Completion Date: *05/14/2024*

Implemented ([redacted] - 05/31/2024)

132e - Fire Drill Sleeping Hours

8. Requirements

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

Description of Violation

The home conducted a sleeping hour drill on 1/27/23 and did not conduct another sleeping hour drill until 10/31/23.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Action: The violation could not be immediately corrected since the fire drills had already been completed.

Additional Corrective Actions: The Maintenance Team was retrained on 4/30/2024 on RCG Requirement 2600.132.e The schedule for fire drills is maintained in TELS, the building management platform, which includes preventative maintenance and fire drills, as required by regulation. The Executive Director will create and monitor the schedule for fire drills and provide Outlook Calendar reminders to the Maintenance Director regarding scheduled drills. This is effective 5/1/2024

Ongoing Quality Assurance Actions: The fire drill schedule and implementation of drills will be reviewed as part of the Quarterly QA process. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in June 2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented ([redacted] - 05/28/2024)

132g - Fire Drills Days/Times

9. 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.

132g - Fire Drills Days/Times *(continued)*

Description of Violation

The home's last 11 fire drills were conducted on the following dates: 4/23/24, 3/28/24, 2/22/24, 1/29/24, 12/18/23, 11/20/23, 10/31/23, 10/27/23, 9/25/23, 8/28/23, and 7/25/23. The home regularly conducts fire drills in the last half of the month, and often in the last week of the month. Also, the home conducted sleeping hour drills on 10/27/23 at 6:05am with 7 staff persons, 10/31/23 at 6:30am with 11 staff persons, and 4/23/24 at 6:05am with 9 staff persons. The home's schedule indicates only 4 to 5 staff persons are in the home during the hours of 11pm to 6am. The home schedules their sleeping hour drills during times in which there is an overlap of shifts and additional staff are present to participate in the drill.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Actions: The violation could not be immediately corrected since the fire drills had already been completed.

Additional Corrective Actions: The Maintenance Team was retrained on 4/30/2024 on RCG Requirement 2600.132.g by Executive Director. The schedule for fire drills is maintained in TELS, the building management platform, which includes preventative maintenance and fire drills, as required by regulation. The Executive Director will create and monitor the schedule for fire drills and provide Outlook Calendar reminders to the Maintenance Director regarding scheduled drills. This is effective 5/1/2024.

Ongoing Quality Assurance Actions: The fire drill schedule and implementation of drills will be reviewed as part of the Quarterly QA process. Findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in June 2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented ([redacted] - 05/31/2024)

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 #9 has an order for metoprolol 50mg one tablet daily. The pharmacy label of the medication did not match the Medication administration record (MAR) because it included an order to hold the medication for systolic blood pressure (SBP) less than 110 which was not a current order.
Resident #10 has an order for Warfarin 2mg tablet one tablet every other day, alternating with 3mg tablets. The previous order of one 2mg tablet daily at bed time was indicated on the pharmacy label.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Actions: On 4/25/24, the Med Tech on shift immediately placed a "Direction Change" sticker on the card for both Residents #9 and #10, directing staff to refer to the chart for changes. Pharmacy was notified of errors in label via fax immediately on day of inspection.

184a - Resident's Meds Labeled (continued)

Additional Corrective Actions: Resident Care Director will ensure that Chart to Cart Audits are completed weekly to ensure compliance, beginning 5/1/2024.
Ongoing Quality Assurance Actions: The Resident Care Director will review weekly Chart to Cart Audits, and findings will be reviewed as part of the Quarterly QA Meetings, beginning June 2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented ([redacted] - 05/28/2024)

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

The home's med techs are required to perform a count of the narcotic drugs at each shift change and to sign the controlled drug count sheet when coming in and leaving their shifts. On the following dates and times the controlled drug count sheet was missing signatures for either the oncoming staff or the staff leaving their shifts: 4/3/24 at 3pm, 4/4/24 at 3pm and 11pm, 4/10/24 at 3pm, and 4/13/24 at 11pm.
Resident #9 had an order for Fluticasone spray, 1 spray into each nostril daily for 14 days. The medication was initialed as administered every morning from 4/1/24 through 4/25/24. The order was changed to 1 spray into each nostril daily as needed but staff continued to initial the medication as administered on the MAR.
Also, resident #11 has an order for Riluzole 50 mg one tablet twice daily. On 4/15/24 the home was notified by the physician to hold the medication for two weeks due to lab testing results. From 4/18/24 through 4/25/24 staff continued to initial the medication as administered in the morning. Staff interviews indicate the medication was held, but was incorrectly initialed as administered.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Action: On 4/25/2024 the violation for Resident #9 was the Med Technician on shift immediately corrected by discontinuing daily administration of medication and began having it be administered as needed. Since that time, the resident has requested the administration of the medication. The violation for Resident #11 was immediately corrected when a note was documented on 4/25/2024 for Resident #11, which noted that medication was held per order.

Additional Corrective Actions: On 4/30/2024, all Medication Technicians were retrained by the Resident Care Director on the completion of the Med Tech Shift Change Responsibly Sheet, including the completion of Narcotics Counts. Resident Care Director will monitor daily to ensure Med Tech Shift Change Responsibility Sheets are being completed and that narcotics are signed out correctly, beginning 5/1/2024.

Ongoing Quality Assurance Actions: Findings, patterns, and trends will be reviewed at Quarterly Quality Assurance Meetings, beginning in June 2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented ([redacted] - 05/28/2024)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #4 has an order for Levothyroxin 137mcg daily. On 4/16/24 the medication was not administered. Resident #12 has an order for Midodrine 5mg, 2 tablets three times daily before meals and hold for SBP greater than 130. The MAR indicates the medication is administered before breakfast, at lunch, and at bedtime, usually between 8pm and 9pm. Also, on 4/11/24 at 10:36pm and 4/14/24 at 10:04pm staff initialed the medication as administered but did not document the resident's SBP. Repeated violation 7/12/23, et al.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Actions: On 4/25/2024, the violation for Resident #4 was immediately corrected when the Med Technician on shift documented in the chart that the medication was administered. At the same time and by the same staff member, the violation for Resident #12 was immediately corrected at the time of survey when the administration times in the MAR were changed to reflect the order.

Additional Corrective Actions: On 4/30/24, Med Technicians, were retrained by the Resident Care Director on proper medication administration and following prescriber's orders including time and parameters.

Ongoing Quality Assurance Actions: The Resident Care Director will review the Daily Dashboard in the SMART system, as well as a monthly sample of MARs for proper documentation and ongoing compliance. Findings, patterns, and trends will be reviewed at Quarterly Quality Assurance Meetings, beginning in June 2024

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented ([redacted] - 05/28/2024)

224a - Preadmission Screen Form

13. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Section II-F of the Pre-Screen form for Resident #3 dated [redacted] was left blank and does not indicate the resident's reason for leaving current residence.

Plan of Correction ***Accept ([redacted] - 05/16/2024)***

Immediate Corrective Action: The Preadmission Screening was completed within 30 days prior to admission to the personal care home, per regulatory guideline. The documentation did not include documentation about prior residence. The Executive Director immediately amended the Preadmission Screening to include information about prior residence.

Additional Corrective Actions: The Resident Care Director or Clinical Care Coordinator will complete preadmission

224a - Preadmission Screen Form (continued)

screenings. The Executive Director will provide additional oversight to review these forms before they are submitted to the resident record, to ensure that incomplete forms are not entered into record, effective 5/1/2024.

Ongoing Quality Assurance Actions: A sample of resident records will be reviewed each month by the Resident Care Director, as part of the Quality Assurance Review. Findings will be reviewed at Quarterly Quality Assurance Meetings, beginning in June 2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented (- 05/28/2024)

227d - Support Plan Medical/Dental

14. 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

The residents listed below all have enabler bars attached to their beds. The support plans for those residents do not include the following required information: the specific need for the enabler bars, the intended use of the device, risks associated with the device, the residents' ability to use the devices safely for the intended purpose, identification of the specific device to be used, and whether the device is required to be covered to meet FDA guidelines:
Resident #2, support plan dated
Resident #3, support plan dated
Resident #5, support plan dated
Resident #13, support plan dated

Plan of Correction ***Accept (- 05/16/2024)***

Immediate Corrective Action: RASP updates for Residents #2, 3, 5, and 13 were reviewed by Physical Therapy and addendums placed in the Resident charts reflecting the specific need for the enabler bar, the intended use of the device, risks associated with the device, the residents ability to use the devices safely for the intended purpose, identification of the specific device to be used, and whether the device is required to be covered to meet FDA guidelines. This was completed 5/7/2024.

Additional Corrective Actions: The Resident Care Director and Physical Therapy Team will be retrained on the Bedside Mobility Device Policy by the Executive Director on 5/13/2024. Beginning 5/13/2024, The Therapy Team will meet with the Resident Care Director and Executive Director to discuss the needs of any resident requiring the use of a Bedside Mobility Device before implementation. The Executive Director will review documentation when completed.

Ongoing Quality Assurance Actions: A summary of residents utilizing Bedside Mobility Devices since the last Quarterly Assurance Meeting will be reviewed by the Executive Director as part of Quality Assurance Review Process, beginning June 2024.

227d - Support Plan Medical/Dental *(continued)*

Licensee's Proposed Overall Completion Date: *05/13/2024*

Implemented ([redacted] - 05/28/2024)