

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

February 24, 2025

[REDACTED], ADMINISTRATOR  
MAPLE SHADE MEADOWS LP  
[REDACTED]

RE: MAPLE SHADE MEADOWS SENIOR  
LIVING  
50 EAST LOCUST STREET  
NESQUEHONING, PA, 18240  
LICENSE/COC#: 20400

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/07/2024 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: *MAPLE SHADE MEADOWS SENIOR LIVING* License #: *20400* License Expiration: *11/20/2024*  
 Address: *50 EAST LOCUST STREET, NESQUEHONING, PA 18240*  
 County: *CARBON* Region: *NORTHEAST*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

Name: *MAPLE SHADE MEADOWS LP*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-1* Date: *10/14/2017* Issued By: *Nesquehoning*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *109* Waking Staff: *82*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
 Reason: *Renewal* Exit Conference Date: *11/07/2024*

**Inspection Dates and Department Representative**

11/07/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *85* Residents Served: *65*

**Secured Dementia Care Unit**  
 In Home: *Yes* Area: *na* Capacity: *25* Residents Served: *12*

**Hospice**  
 Current Residents: *10*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *65*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *44* Have Physical Disability: *0*

**Inspections / Reviews**

**11/07/2024 - Full**  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/28/2024*

**12/04/2024 - POC Submission**  
 Submitted By: [REDACTED] Date Submitted: *01/12/2025*  
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/09/2024*

Inspections / Reviews *(continued)*

12/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/12/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/12/2025

02/24/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/12/2025

Reviewer: [REDACTED]

Follow-Up Type: Not Required

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

*Staff persons A and B did not receive training in the following required annual training topics for 2023: Medication self administration, instruction on meeting the needs of the residents as described in the medical evaluations and support plans, and safe management techniques. Also, staff person B did not receive training in the required annual training topic care for residents with dementia and cognitive impairment. Staff person A was hired [REDACTED] and staff person B was hired [REDACTED]. Repeated violation 10/11/23 et al.*

Plan of Correction

Directed ([REDACTED] - 12/12/2024)

*Staff members were educated on the importance of attending annual training.  
 Staff were advised that annual training is mandatory.  
 Administrator is responsible for fixing the problem.  
 Administrator created new training documentation sheets in order to closely monitor staff's participation in annual training.  
 Administrator will be responsible for continued compliance and monitoring staff attendance on a monthly basis.  
 Update: All staff attended meeting on 11/12/24-where we discussed plan of correction and importance of attending staff training. Administrator created new training sheets to be able to better monitor compliance, as well as created online staff trainings for staff to remain in compliance.*

*Proposed Overall Completion Date: 12/09/2024*

**Directed Plan of Correction:**

***Staff members A and B will be trained in medication self-administration, instruction on meeting the needs of the residents as described in the medical evaluations and support plans, and safe management techniques for the 2023-year training year. Staff members A and B will also be trained in all required topics for 2024 training year. Administrator will audit all staff members 2023 training and retrain any staff members missing the required training in 2023. Training shall be completed within 30 days.***

*Proposed Overall Completion Date: 01/09/2025*

65f - Training Topics (continued)

Directed Completion Date: 01/12/2025

Implemented ( ) - 02/24/2025

65g - Annual Training Content

2. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons A, B, and C did not receive the following required annual training topics for 2023:

Fire safety by a fire safety expert, emergency preparedness procedures, and falls and accident prevention. Also, staff person C did not receive training in the required annual training topics resident rights and Older Adult Protective Services Act (OAPSA). Staff person A was hired [REDACTED] Staff person B was hired [REDACTED] Staff person C was hired [REDACTED]

Plan of Correction

Directed ( ) - 12/12/2024

Staff members were educated on the importance of attending annual training.

Staff were advised that annual training is mandatory.

Administrator is responsible for fixing the problem.

Administrator created new training documentation sheets in order to closely monitor staff's participation in annual training.

Administrator will be responsible for continued compliance and monitoring staff attendance on a monthly basis.

Facility annual fire safety training is expected May 2024. Administrator reached out to fire safety expert for training date- awaiting further response.

Education provided to staff 11/12/14.

Proposed Overall Completion Date: 12/09/2024

Directed Plan of Correction:

**Staff members A, B, and C will be trained fire safety by a fire safety expert, emergency preparedness procedures, and falls and accident prevention. for the 2023-year training year. Staff members A, B, and C will also be trained in all required topics for 2024 training year. Administrator will audit all staff members 2023 training and retrain any staff members missing the required training in 2023. Training shall be completed within 30 days.**

Directed Completion Date: 01/12/2025

65g - Annual Training Content (continued)

Implemented ( ) - 02/24/2025)

82c - Locking Poisonous Materials

3. 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

During the initial walkthrough and inspection of the home's memory care unit, a bottle of hand sanitizer containing alcohol and a bottle of moisturizer were found in the kitchenette area unlocked and accessible to residents who have been assessed as unsafe to use or avoid cleaners and poisonous materials.

Plan of Correction

Accept ( ) - 12/12/2024)

Hand sanitizer and moisturizer were immediately removed and locked.

All staff were provided education on 2600.82.c

Memory Care Director is responsible for fixing the problem.

Memory Care Director and med-tech on duty will be responsible for monitoring daily compliance in memory care unit by utilizing a newly created compliance checklist.

Administrator and Assistant Administrator will complete rotating weekly compliance checks in memory care to ensure ongoing compliance.

Education completed 11/12/24

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( ) - 02/24/2025)

85a - Sanitary Conditions

4. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The glucometer belonging to resident #1 had a dried red substance on it that appeared to be blood. The glucometer was not sanitized after use.

Plan of Correction

Accept ( ) - 12/12/2024)

Staff members were educated on the importance of 2600.85(a) and infection control.

Director of nursing is responsible for fixing the problem.

Med-Tech on duty will be responsible for daily compliance.

Director of Nursing will be responsible for monitoring compliance of glucometers, including sanitary conditions, on a weekly basis and completing a newly created compliance checklist.

Care Coordinator to perform glucometer compliance/sanitary checks on a monthly basis to ensure compliance.

Education completed 11/12/24

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( ) - 02/24/2025)

91 - Telephone Numbers

5. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

*The telephone located in the A hall did not have the required emergency phone numbers posted on or near the phone.*

Plan of Correction

Accept (█ - 12/12/2024)

*Management staff was educated on the importance of 2600.91.*

*Phone number list was immediately posted by telephone in A-Hall.*

*Administrator will be responsible for fixing the problem and monitoring for ongoing compliance.*

*Administrator will be responsible for completing bi-weekly checks to ensure numbers are posted by all phones.*

*Education completed 11/12/24. Administrator will fix the problem by ensuring all phones have emergency telephone number by them. Safety committee will also perform audits on their monthly building checks to ensure compliance.*

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented (█ - 02/24/2025)

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

*During the initial walkthrough and inspection of the memory care unit, two bags of frozen, peeled bananas and a bag of frozen bread were found in the freezer of the kitchenette area. The bags were not labeled and dated with the contents of the bags or the dates the food items were stored in the freezer.*

Plan of Correction

Accept (█ - 12/12/2024)

*Staff was provided education on 2600.103e.*

*Food that was unlabeled or not dated was immediately discarded.*

*Memory Care director is responsible for fixing the problem and monitoring compliance on an ongoing basis.*

*Memory Care Director and Nightshift staff will be responsible for completing weekly refrigerator checks to ensure ongoing compliance and completing a newly created compliance checklist.*

*Dietary Director, Administrator and Assistant Administrator will complete random audits in memory care on a monthly basis to ensure ongoing compliance.*

*Education was completed 11/12/24*

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented (█ - 02/24/2025)

103g - Storing Food

7. Requirements

2600.

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

103g - Storing Food (continued)

**Description of Violation**

*During the initial walkthrough and inspection of the memory care unit, a Ziploc bag of bacon bits was found in the refrigerator not properly sealed as it had not been zipped shut. Also, there were six bottles of salad dressings stored in the refrigerator in bottles with pour-style lids that were uncovered.*

**Plan of Correction**

Accept ( ) - 12/12/2024

*Staff was provided education on 2600.103g.*

*Refrigerator in memory care was immediately checked, and the issues were fixed.*

*Memory Care director is responsible for fixing the problem and monitoring compliance on an ongoing basis.*

*Memory Care Director and Nightshift staff will be responsible for completing weekly refrigerator checks to ensure ongoing compliance by completing compliance checklist.*

*Dietary Director, Administrator and Assistant Administrator will complete random audits in memory care on a monthly basis to ensure ongoing compliance.*

*Education was completed 11/12/24*

**Licensee's Proposed Overall Completion Date: 12/09/2024**

Implemented ( ) - 02/24/2025

107c - Food/Water 3 Day Supply

**8. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

**Description of Violation**

*The home's census during the inspection was 65. The home is required to store 195 gallons of drinking water on site as per this regulation. The home had only 189 gallons of drinking water on hand. There was no documentation available to state that the home has a contract with a water supply company to deliver water to the home for emergency purposes.*

**Plan of Correction**

Accept ( ) - 12/12/2024

*Management was educated on 2600.107(g)*

*Maintenance Director immediately purchased additional water to ensure compliance.*

*Maintenance Director is responsible for fixing the problem and ensuring ongoing compliance.*

*Education was completed 11/12/24*

*Maintenance Director will ensure adequate water supply to remain in compliance with 2600.107(c) on an ongoing and weekly basis.*

*Administrator and Assistant Administrator will complete random bi-weekly audits of food and water supply to ensure compliance.*

**Licensee's Proposed Overall Completion Date: 12/09/2024**

Implemented ( ) - 02/24/2025

121a - Unobstructed Egress

**9. Requirements**

2600.

121a - Unobstructed Egress (continued)

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The door leading to the enclosed patio located in the home's memory care unit did not have signage on or near the door to indicate the door is not an exit. The door leads to a fenced in patio that has no means of egress from the patio.

Plan of Correction

Accept ( ) - 12/12/2024)

Staff was educated on 2600.121(a).

"This is not an exit" sign was immediately placed on door that leads to fenced in patio.

Maintenance Director is responsible for fixing the problem and will be responsible for ongoing compliance and complete random monthly checks on 2600.121.(a)

Administrator and Assistant Administrator to randomly audit for ongoing compliance on a monthly basis.

Sign was posted on date of inspection, 11/7/24/

Education completed with staff 11/12/24.

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( ) - 02/24/2025)

131f - Fire Extinguisher Inspection

10. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

During the initial walkthrough and inspection the fire extinguisher located in the outdoor courtyard smoking area had a inspection sticker on it that indicated the inspection expired May 2024.

Plan of Correction

Accept ( ) - 12/12/2024)

Management staff was educated on the importance of 2600.131(f).

Maintenance Director is responsible for fixing the problem and immediately placed a fire extinguisher that is appropriately dated in the courtyard and requested fire extinguisher that was out of compliance be inspected and dated.

Maintenance Staff and Director to complete audits on fire extinguishers to ensure compliance to 2600.131(f) on a monthly basis.

Administrator and Assistant Administrator to randomly audit for compliance on a semi-annual basis.

Education to staff completed 11/13/24

New Fire extinguisher placed in courtyard on 11/8/24.

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( ) - 02/24/2025)

132c - Fire Drill Records

11. 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 home's fire drill logs indicate a fire drill was conducted on 10/24/24 at 2pm. According to staff interview with the home's administrator, resident #2 was not evacuated to a fire safe area during the fire drill. The fire drill logs indicate that 66 residents were present in the home at the time of the fire drill and 66 residents were evacuated. There is no notation on the fire drill log to indicate that resident #2 was not evacuated to a fire safe area during the drill.

**Plan of Correction**

Accept (█ - 12/12/2024)

Staff was educated on 2600.132(c).

Management concluded that all residents will be evacuated during a fire drill.

Administrator is responsible for fixing the problem and will monitor fire drills for continued compliance on an immediate and ongoing basis.

Administrator and Assistant Administrator will be responsible for being present at all monthly fire drills in order to ensure compliance with 2600.132(c).

Education to staff completed 11/12/24

Administrator/ Assistant Administrator will ensure all residents are evacuated during all drills, by completing walking rounds during all fire drills.

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented (█ - 02/24/2025)

132h - Designated Meeting Place

**12. Requirements**

2600.

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

**Description of Violation**

The home's fire drill logs indicate a fire drill was conducted on 10/24/24 at 2pm. Resident #2 was not evacuated to a fire safe area during the drill.

**Plan of Correction**

Accept (█ - 12/12/2024)

Staff was educated on 2600.132(h).

Management concluded that all residents will be evacuated during a fire drill.

Administrator is responsible for fixing the problem and will monitor fire drills for continued compliance on an immediate and ongoing basis and that all residents will be evacuated and meet at a designated meeting place.

Administrator and Assistant Administrator will be responsible for being present at all monthly fire drills in order to ensure compliance with 2600.132(c).

Administrator/ Assistant Administrator will ensure all residents are evacuated to safe areas during all drills, by completing walking rounds during all fire drills.

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented (█ - 02/24/2025)

187d - Follow Prescriber's Orders

13. Requirements

2600.

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

**Description of Violation**

*Resident #3 has an order for Niphedipine ER 90mg, one tablet every morning, hold for systolic blood pressure (SBP) less than 115. On 11/6/24 and 11/7/24 the SBP readings were 86 and 89 respectively. The Medication administration record (MAR) indicates that the medication was not held as per the prescriber's orders on 11/6/24 and 11/7/24.*

*Resident #3 also has an order for Losartan POT 50mg, one tablet twice daily, hold for SBP less than 115. On 11/6/24 at 6pm the SBP reading was 113. The MAR indicates the medication was not held as per the prescriber's orders on 11/6/24 at 6pm.*

**Plan of Correction**

Accept (█) - 12/12/2024)

*All medication staff were educated on 2600.187(d).*

*Director of Nursing and Memory Care Director will be responsible for fixing the problem and ensuring compliance on an immediate and ongoing basis.*

*Director of Nursing and Memory Care Director audit random resident MAR on a weekly basis.*

*Administrator and Assistant Administrator will audit random resident MAR on monthly basis to ensure continued compliance.*

*Staff was educated on 11/12/24.*

*Audits will be completed on a monthly basis-first monthly audit post inspection planed for 12/12/24.*

**Licensee's Proposed Overall Completion Date: 12/09/2024**

Implemented (█) - 02/24/2025)

225a - Assessment 15 Days

14. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

**Description of Violation**

*Resident #4 was admitted to the home on █. The support plan indicates an initial assessment for resident #4 was not completed within 15 days of admission. The initial assessment was completed on █.*

**Plan of Correction**

Accept (█) - 12/12/2024)

*Staff was educated on 2600.225(a).*

*Care Coordinator will be responsible for fixing the problem and ensuring continued compliance.*

*Care Coordinator completed chart audits to ensure compliance going forward.*

*Care Coordinated re-educated on requirements of 2600.225(a) and going forward will ensure assessments will be completed in compliance with regulations.*

*Care Coordinator created chart in order to monitor compliance.*

*Administrator and Assistant administrator to complete random chart audits on monthly basis to ensure ongoing compliance.*

*Staff was educated on 11/12/24.*

*First monthly audit post inspection to be completed the week of 12/16/24*

**Licensee's Proposed Overall Completion Date: 12/16/2024**

225a - Assessment 15 Days (continued)

Implemented ( ) - 02/24/2025)

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 #5 has an order for a mechanical soft diet. The support plan dated ( ) does not reflect that the resident has this dietary requirement.

Resident # 6 has an enabler bar attached to their bed. The support plan dated ( ) for resident #6 does not include the following information:

- The specific need for the device
- The intended use and any risks associated with the use
- The resident’s ability to use the device safely for the purpose it was intended
- Identification of the specific device to be used and whether a cover is required to meet FDA guidelines

Also, resident #6 has an order for a mechanical soft diet. The support plan dated ( ) for resident #6 also did not indicate that the resident has this dietary requirement.

Repeated violation 10/11/23 et al.

Plan of Correction

Accept ( ) - 12/11/2024)

Staff was educated on 2600.227(d).

Care Coordinator will be responsible for fixing the problem.

Care Coordinator will work with Director of Nursing and Memory Care Director to ensure support plans are up-to-date and include all resident needs, as resident needs change.

Administrator and Assistant Administrator will be responsible for completing random monthly chart checks in order to ensure ongoing compliance.

Staff education was provided 11/12/24.

Audits will be completed randomly monthly-first date expected 12/12/24.

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( ) - 02/24/2025)

231c - Preadmission Screening

16. 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 #7 was admitted to the homes secure dementia care unit on ( ). The home did not complete a cognitive preadmission screening prior to or on the day of the resident’s admission to the secure dementia unit as required.

231c - Preadmission Screening (continued)

Repeated violation 10/11/23 et al.

Plan of Correction

Accept ( [redacted] - 12/11/2024)

Staff was educated on 2600.231(c).

Facility recently hired new admission director to ensure ongoing compliance.

Charts were audited to ensure compliance going forward.

Admissions Director will be responsible for fixing the problem and ensuring ongoing compliance with 2600.231(c).

Administrator and Assistant Administrator to complete random monthly chart audits to ensure ongoing compliance.

Staff was educated 11/12/24

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( [redacted] - 02/24/2025)

231e - No Objection Statement

17. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #8 was admitted to the home's secure dementia unit on [redacted]. The home did not have documentation that the resident and the resident's designated person have not objected to the resident's admission to the secure dementia unit.

Repeated violation 10/11/23 et al.

Plan of Correction

Accept ( [redacted] - 12/11/2024)

Staff was educated on 2600.231(e).

Facility recently hired new admission director to ensure ongoing compliance.

Chart audits were completed for residents requiring no object statements to ensure compliance going forward.

Admissions Director will be responsible for fixing the problem and ensuring ongoing compliance with 2600.231(e).

Administrator and Assistant Administrator to complete random monthly chart audits to ensure ongoing compliance.

Staff education regarding Inspection and compliance took place 11/12/24.

Chart audits will happen monthly on a random basis starting the week of 12/16/24

Licensee's Proposed Overall Completion Date: 12/09/2024

Implemented ( [redacted] - 02/24/2025)

236 - Staff Training

18. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Staff persons A and B did not receive the required six hours of dementia training for the 2023 training year. Both staff persons A and B completed only two hours of dementia training for the 2023 training year. Staff person A was hired [redacted] and staff person B was hired [redacted]

236 - Staff Training (continued)

**Plan of Correction**

**Accept (█ - 12/11/2024)**

*Staff members were educated on the importance of attending annual training, specifically 2600.236.*

*Staff were advised that annual training is mandatory.*

*Administrator is responsible for fixing the problem.*

*Administrator created new training documentation sheets in order to closely monitor staff's participation in annual training.*

*Administrator will be responsible for continued compliance and monitoring staff attendance on a monthly basis.*

*Education was provided to the staff 11/12/24.*

*Administrator will fix the problem by offering alternate training solutions, such as virtual trainings to staff members.*

*Administrator will audit new training sheets after each required training to ensure all staff is in compliance.*

**Licensee's Proposed Overall Completion Date: 12/09/2024**

**Implemented (█ - 02/24/2025)**