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

February 13, 2025

[redacted], CEO
ELM TERRACE GARDENS
660 NORTH BROAD STREET
LANSDALE, PA, 19446

RE: ELM TERRACE GARDENS
660 N. BROAD ST., 3RD & 4TH FL
LANSDALE, PA, 19446
LICENSE/COC#: 12783

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/25/2024, 11/26/2024, 12/23/2024 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: *ELM TERRACE GARDENS* **License #**: *12783* **License Expiration**: *06/10/2025*

Address: *660 N. BROAD ST., 3RD & 4TH FL, LANSDALE, PA 19446*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ELM TERRACE GARDENS*

Address: *660 NORTH BROAD STREET, LANSDALE, PA, 19446*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *05/01/1992* **Issued By**: *Borrough of Lansdale*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *131* **Waking Staff**: *98*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *12/23/2024*

Inspection Dates and Department Representative

11/25/2024 - On-Site: [redacted]
11/26/2024 - On-Site: [redacted]
12/23/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *250* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *7th Street and Walnut Street* **Capacity**: *24* **Residents Served**: *21*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

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

Have Mobility Need: *48* **Have Physical Disability**: *0*

Inspections / Reviews

11/25/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/09/2025*

01/14/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/19/2025*

01/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/11/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/31/2025*

02/13/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/11/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 11/25/24, at 10 am, binders containing resident hospice information, resident's Accu-Chek information, and resident lab work information were observed to be unlocked, unattended, and accessible on the 3rd-floor nurses station's counter. The binders were accessible to any visitor or non-medical staff.

Plan of Correction ***Accept (- 01/23/2025)***

Immediately during survey, Administrator along with Clinical Director removed all binders related to resident records and confidentiality. Personal Care staff working at nursing stations will remind all outside agencies such as hospice, therapy, lab company or any other resident health and personal information to not be stored on the counters on both 3rd and 4th floor.

Starting the week of 11/5/24, Administrator started weekly audits to make sure no resident information is on the counters on both 3rd and 4th floor.

Audits will continue until 1/27/2025 to ensure that no binders or resident records are accessible to any visitors or non-medical staff.

Ongoing Quality Assurance Actions: The Administrator will supervise all resident record areas in the home to make sure they are not accessible to visitors or non- medical staff to ensure all requirements under section 2600.17 are being followed as outlined. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

Confidentiality training was provided to all Direct care workers and nurses on where to store all medical information and ensure that confidently is being maintained. As trained that all books are to be kept behind the nursing station training was held on 1/15/2025

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented (- 02/13/2025)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated , for resident #1 indicates the resident requires assistance with supervision

23a - Activities of Daily Living Assistance (continued)

. Per support plan, the resident needs extensive supervision due to elopement history. Resident #1's support plan indicates they are to have safety checks and that they wear a pendant that is to alert staff of residents wandering or elopement from the SDCU. The home does not document any safety checks for Resident #1 and as per staff reports, the resident does not have a pendant or WanderGuard. On [redacted], Resident #1 did not receive this supervision assistance as required. Resident#1 eloped from the SDCU and was not found [redacted] by Police, at an off site location approximately 1 mile away from the home. Staff member B, who was assigned to the SDCU area where resident #1 resides, was in an office with a closed door at the time that resident #1 eloped. Staff member B could not hear the alarm sounding due to the closed office door and was not aware of that a resident eloped until Staff member A alerted them to the fact that an alarm was triggered and that the staff must conduct a resident head count. During the resident head count, it was discovered that Resident #1 was missing.

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

Directly after inspection on 11/27/2024, Administrator conducted a 1:1 in person training with Clinical Director on making sure SDCU staff are aware of resident's support plans especially those with supervision needs. Additional training will be provided to any new staff working in the SDCU so they are aware of all resident's assessment and support plan needs.
On 11-7-24, Elm Terrace Gardens updated the SARA system dashboard and eMessenger phone application. A delay has been programmed on any doors that open or close for the alarm to stay active for a solid 10 minutes on eMessenger and SARA dashboard. This update will help staff see the alarm on their phones.
On 11-15-2024 Nurse educator conducted training on this update for eMessenger and SARA dashboard.
On 12-5-2024 Nurse educator conducted an elopement drill for Personal Care and SDCU.
On 12-31-24 Nurse educator conducted abuse, neglect and elopement in-service for staff who work on the SDCU.
On 1-6-2025 Personal Care Clinical Director created a 2-hour safety check for resident 1 along with any other residents with a history of exit seeking behaviors. A roam alert pendent was added to resident #1 for added safety measures.
Administrator or Clinical Director will complete weekly audits to ensure 2-hour safety checks are being completed. Audits will continue for one month ending on February 9, 20025.
Administrator along with Clinical Director with make sure all RASP's are accurate for resident's current needs and will make adjustments accordingly. Any changes to resident care needs such as supervision changes will be communicated to staff on an as needed basis.

**11/15/2024 all nurses and direct care workers received training*
**staff was trained and checking along with the 2 hour checks that the pendant is in place. It is also a order in the MAR for it to be checked by the med tech weekly, task in POC for the aides daily as well.*
**the expiration of the pendant is listed in the MARs for the entire pendant to be changed for the battery life*
** the audit was completed on all the rasp today 1/17/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented ([redacted] - 02/13/2025)

42b - Abuse

3. Requirements

2600.

42b - Abuse *(continued)*

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], Resident #1, who resided on the 7th Street area of the SDCU, eloped from the SDCU by using the 7th Street fire stairwell exit by pushing the delayed egress bar and holding it down until the lock disengaged and the alarm sounded. Resident continued down the stairs, out the door and onto the sidewalk, and continued walking. This emergency exit stairwell leads to two lane residential street, that intersects a much busier main road with both residential and commercial traffic, and near by a busy train station and train yard about 1/2 mile away from the home. Resident was wearing a long-sleeved gray shirt and dark colored pants, and shoes, but no coat. The outside temperature over night on [redacted] was approximately 47 degrees F.

The SDCU emergency exit doors are equipped with 15-second delayed release push bars. These delayed egress bars will disengage the magnetic lock on the door once the push bar is engaged for 15 or more seconds, at which time the door will unlock, and an alarm will sound. When an alarm is triggered, a notification is supposed to be sent to the staff's communication devices or SARA Alert cell phones, to identify which door has a triggered alarm. Staff member A and B both report that their devices did not receive a notification of an activated alarm at the time that Resident #1 eloped.

At [redacted], a security guard viewing the video monitors of the homes exits, noticed a person leaving the 7th Street area external doors, at which time they contacted Staff Member B who was working in the Walnut Street area of the SDCU, to ask if an alarm was going off anywhere in SDCU. Staff member B reported that there was no alarm sounding in the Walnut Street area and immediately went to check the 7th Street area, located in a different secured area. Staff Member B arrived on the 7th Street SDCU area, and reported hearing an alarm sounding, and found Staff Member A in an office, who was not aware of the alarm. Staff member B could not hear the door alarm with the office door closed. Staff Member B also reported not knowing that the home's policy is that staff are not permitted to be in that office while on shift.

Staff Member A made Staff member B aware that that an alarm was triggered, and a resident head count was immediately initiated, during which the staff members identified that Resident #1 was missing. Staff then initiated a search for the resident as per the homes policy. The police were contacted via 911 after the staff failed to locate the resident on the property and in the immediate surrounding area, approximately 15 minutes later.

At [redacted] Resident #1 was found by the police approximately 1 mile from the home in a fast food restaurant parking lot along North Broad Street. The police took Resident #1 to the emergency room for evaluation. Resident #1 returned to the community at [redacted] from the hospital with no new injury or physician orders.

Resident #1s support plan dated [redacted] preadmission screening form, and staff assignment list/notes all identify Resident #1 as an elopement risk. Resident #1 has a history of exit seeking behaviors as recently as [redacted] when Resident #1 had to be escorted back into the SDCU after holding the push bar down on a different door, though Resident #1 did not leave the property on this date. Resident #1's [redacted] support plan also indicates that Resident #1 will have safety checks and has a pendant that will alert if the resident leaves the property. There was no documentation of safety check being performed for Resident #1, and staff report that Resident #1 does not use a WanderGuard or pendant.

42b - Abuse (continued)

Repeat Violation Date: 5/29/24, 11/16/23; 9/21/23 et al.

Plan of Correction ***Accept (- 01/23/2025)***

Immediately following the incident on [redacted] Administration started an internal investigation on how resident #1 was able to get out of 7th street stairways. All staff members working the evening of [redacted] were required to give written statements of the event. Discovery of this incident showed that the concierge staff immediately noticed a resident on security camera along with Sara alert system dashboard and contacted SDCU unit. Staff member B who was working in the connected SDCU unit immediately heard the alarm on 7th street and found staff person A in the office who was unable to hear the alarm sounding. Both staff members said they did not get any notification of an activated alarm on their assigned devices. At this time, a head count was completed and identified resident #1 was missing. Staff immediately started a search following homes policy for missing resident. 911 was contacted and resident was found safe 15 minutes later.

On 11-7-24, Elm Terrace Gardens updated the SARA system dashboard and eMessenger phone application. A delay has been programmed on any doors that open or close for the alarm to stay active for a solid 10 minutes on eMessenger and SARA dashboard. This update will help staff see the alarm on their phones.

On 11-15-2024 Nurse educator conducted training on this update for eMessenger and SARA dashboard.

On 12-5-2024 Nurse educator conducted an elopement drill for Personal Care and SDCU.

On 12-31-24 Nurse educator conducted abuse, neglect and elopement in-service for staff who work on the SDCU.

Personal Care Clinical Director created a 2-hour safety check for resident 1 along with any other residents with a history of exit seeking behaviors. A roam alert pendent was added to resident #1 for added safety measures.

Administrator or Clinical Director will complete weekly audits to ensure 2-hour safety checks are being completed. Audits will continue for one month ending on February 9, 20025.

**all direct care workers and nurses were trained in 11-15-2024*
** staff was trained on q2hour safety checks as well as checking placement of the pendent and ensure functioning*
**orders were placed in the MARs for the med techs to check weekly and tasks for the aides for daily check*
**audit for the rasp were completed on 1/17/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented (- 02/13/2025)

65g - Annual Training Content

4. 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.

65g - Annual Training Content *(continued)*

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 person C and D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year January 2023 to December 2023.

Plan of Correction ***Accept (- 01/14/2025)***

Staff members C and D received fire safety training from Director of Education who is certified by a fire safety expert on 1-07-2025.

Administrator along with Human Resources will make sure all new hires go through fire safety training plus will ensure all staff will complete annual fire safety training which is tentatively set for June 25, 2025. At this time, a current list of all employees will be kept to shown which staff still needs the required training before the year ends.

Ongoing Quality Assurance Actions: The Administrator will supervise monthly trainings to ensure all requirements under section 2600.65.g are being met by Personal Care staff for the calendar year 2025. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/13/2025)

132c - Fire Drill Records

5. Requirements

2600.

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 record for the drill conducted on 03/13/24, 04/24/24, 05/30/24, 06/18/24, 07/24/24, 08/28/24, 09/25/24, and 10/28/24 does not include the exact time it took for the evacuation. The record includes minutes, but no seconds.

Plan of Correction ***Accept (- 01/14/2025)***

Immediately after inspection completion on 11/27/24, Personal Care Administrator had a 1:1 conversation with Environmental Services Director about future fire drill requirements outlined in section 2600.132 c and g.
Starting immediately for November 2024 and beyond, Personal Care will follow the Fire Safety Expects plan dated 6-18-2024 which gives Elm Terrace Gardens 13 minutes to evacuate to designated fire safe areas.
Fire Drills were conducted in both November and December 2024, both following the current information needed under 132c fire drill record.
Ongoing Quality Assurance Actions: The Administrator will supervise monthly fire drills to ensure all requirements under section 2600.132 are being followed as outlined. Findings, patterns and trends will be reviewed during each

132c - Fire Drill Records (continued)

of the homes ongoing quarterly quality assurance meetings

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/13/2025)

132g - Fire Drills Days/Times

6. 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.

Description of Violation

The home routinely holds fire drills during the last week of each month, as evidenced by the following drills 05/30/24, 07/24/24,08/28/24, 09/25/204 and 10/28/24.

Plan of Correction ***Accept (- 01/14/2025)***

Immediately after inspection completion on 11/27/24, Personal Care Administrator had a 1:1 conversation with Environmental Services Director about future fire drill requirements outlined in section 2600.132 c and g.
Starting immediately for November 2024 and beyond, Personal Care will follow the Fire Safety Expects plan dated 6-18-2024 which gives Elm Terrace Gardens 13 minutes to evacuate to designated fire safe areas.

Fire Drills were conducted in both November and December 2024, both following the current information needed under 132c fire drill record.

The homes Environmental Services Director and Administrator will continue to review the yearly schedule when created to prevent repeating the same days of the week. When and if a drill needs to be rescheduled in the community for any reason, the homes Environmental Services Director will send a private calendar update to the homes Administrator, and the Administrator will check the new date and time to prevent any further reoccurrence. Administrator will make sure future fire drills are occurring on different days and times. Day of the week has been added to fire drill record to keep track of which days are being used for fire drills.

Ongoing Quality Assurance Actions: The Administrator will supervise monthly fire drills to ensure all requirements under section 2600.132 are being followed as outlined. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/13/2025)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 11/26/24, Apotex 5mg prescribed for resident #2, was in the home's medication cart; however, the label on the medication bottle indicates that the medicine expired on 10/05/24.

On 11/26/24, Resident#3's Novolog with an open date of 10/22/24, was in the medication's cart. According to the manufacturer's instructions unused medication must be discarded 30 days after opening.

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

On 11/26/2024 both residents' medication Apotex 5mg and Novolog were removed from med cart and destroyed appropriately.
Clinical Director completed in-service training to nursing or med techs on Managing medication carts for expired medication or discontinued, available PRN medications and making sure all medication give was recorded correctly on Emar.

Unit clerk and or Clinical Director will conduct weekly medication cart audits to ensure compliance.

Ongoing Quality Assurance Actions: The Clinical Director will review medication audits to ensure all requirements under section 2600.183 are being followed as outlined. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

**12/27/2024 training was conducted to all med tech and nursing to ensure that each medication is stored in appropriate container and storing them appropriately*

** weekly cart audit began week of 1/6/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented ([redacted] - 02/13/2025)

185a - Implement Storage Procedures

8. 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 #2 is prescribed Acetaminophen 325mg as needed. On 11/26/24 this medication(s) was not available in the home.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

Resident #2 acetaminophen was ordered and will be available in the home.

Clinical Director completed in-service training to nursing or med techs on Managing medication carts for expired medication or discontinued, available PRN medications and making sure all medication give was recorded correctly on Emar.

Unit clerk and or Clinical Director will conduct weekly medication cart audits to ensure compliance.

Ongoing Quality Assurance Actions: The Clinical Director will review medication audits to ensure all requirements under section 2600.185 are being followed as outlined. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

**1/6/2025 all med tech and nurses were trained to ensure all PRN are ordered and, on the cart, as well as removing all expired medication or meds that are discontinued are removed from the cart*

**weekly cart audit started 1/6/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented ([redacted] - 02/13/2025)

187b - Date/Time of Medication Admin.

9. Requirements

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

Description of Violation

Resident #4 is prescribed Oxycodone 5mg-325, once daily in the morning and as needed every 4 hours. Resident#4's November 2024 medication administration record does not include the initials of the staff person who administered Oxycodone 5mg-325 on 11/22/24 at 6:27pm, 9pm and on 11/23/24 at 10pm.

Plan of Correction ***Accept ([redacted] - 01/23/2025)***

Clinical Director completed in-service training to nursing or med techs on Managing medication carts for expired medication or discontinued, available PRN medications and making sure all medication give was recorded correctly on Emar.

Unit clerk and or Clinical Director will conduct weekly medication cart audits to ensure compliance.

Ongoing Quality Assurance Actions: The homes Clinical Director will use the EMAR Dashboard to review medication administration process and documentation and provide oversight to all staff. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings.

**Training was conducted on 1/6/2025*
** cart audit started the week of 1/6/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

187b - Date/Time of Medication Admin. *(continued)*

Implemented (- 02/13/2025)

231b - Medical Evaluation

10. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on ; however, the resident's medical evaluation was completed on

Plan of Correction ***Accept (- 01/14/2025)***

Administrator immediately following inspection on 11/27/24 had a meeting with Clinical Director to make sure all residents admitted into Aspire (SDCU) will have a medical evaluation completed within 60 days according to above regulation 2600.231.b.

On November 27, 2024, Administrator checked the remaining SDCU residents' medical evaluation to make sure all are within 60 days of admission.

Ongoing Quality Assurance Actions: The homes Administrator review all new residents' medical evaluations to make sure the date of move in is within 60 days that are completed to ensure compliance. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/13/2025)

234b - Support Plan Needs Elements

11. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated , for resident #1 indicates the resident has no need related to safely using or avoiding poisonous materials, however resident #1 resides in the SDCU area and has not been assessed as capable of safely using or avoiding poisons.

The support plan, dated , for resident #5 indicates the resident has no need related to safely using or avoiding poisonous materials, however resident #5 resides in the SDCU area and has not been assessed as capable of safely using or avoiding poisons.

Plan of Correction ***Accept (- 01/23/2025)***

Since both resident #1 and #5 reside on SDCU residents are not safe to using or avoiding poisons. Both support

234b - Support Plan Needs Elements (continued)

plans have been updated to reflect that both residents cannot safely use or avoid poisons.

Clinical Director reviewed all current residents in Personal Care SDCU to make sure their support plans are accurate for physical, medical, social, cognitive and safety needs.

Administrator along with Clinical Director with make sure all RASP's are accurate for resident's current needs and will make adjustments accordingly. Any changes to resident care needs such as supervision changes will be communicated to staff on an as needed basis.

Ongoing Quality Assurance Actions: The Administrator along with Clinical Director will review all SDCU residents Support Plans to ensure all requirements under section 2600.234 are being followed as outlined. Findings, patterns and trends will be reviewed during each of the homes ongoing quarterly quality assurance meetings

** all support plans were audited on 1/17/2025*
** aa review of completion if the nurses RASP upon completion of them to be signed off and approved by the clinical director beginning 1/17/2025*

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented ([redacted] - 02/13/2025)