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

March 21, 2025

[redacted] PRESIDENT/CEO
BAPTIST HOMES SOCIETY
[redacted]

RE: PROVIDENCE POINT
200 ADAMS AVENUE
PITTSBURGH, PA, 15243
LICENSE/COC#: 44143

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/09/2024, 12/10/2024 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**: *PROVIDENCE POINT* **License #**: *44143* **License Expiration**: *01/04/2025*

**Address**: *200 ADAMS AVENUE, PITTSBURGH, PA 15243*

**County**: *ALLEGHENY* **Region**: *WESTERN*

## Administrator

**Name**: **Phone**: **Email**:

## Legal Entity

**Name**: *BAPTIST HOMES SOCIETY*
**Address**:
**Phone**: **Email**:

## Certificate(s) of Occupancy

**Type**: *I-1* **Date**: *06/09/2009* **Issued By**: *Scott Township*
**Type**: *I-2* **Date**: *11/10/2009* **Issued By**: *Scott Township*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *94* **Waking Staff**: *71*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *12/10/2024*

## Inspection Dates and Department Representative

*12/09/2024 - On-Site:*
*12/10/2024 - On-Site:*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *84* **Residents Served**: *61*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *1st Floor* **Capacity**: *20* **Residents Served**: *18*

### Hospice

**Current Residents**: *9*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *61*
**Diagnosed with Mental Illness**: *0* **Diagnosed with Intellectual Disability**: *0*
**Have Mobility Need**: *33* **Have Physical Disability**: *0*

## Inspections / Reviews

### 12/09/2024 Full

**Lead Inspector**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/28/2024*

## Inspections / Reviews *(continued)*

### 01/07/2025 POC Submission

**Submitted By:** [redacted]
**Date Submitted:** *12/27/2024*
**Reviewer:** [redacted]
**Follow Up Type:** *POC Submission*
**Follow Up Date:** *01/13/2025*

### 02/07/2025 POC Submission

**Submitted By:** [redacted]
**Date Submitted:** *01/16/2025*
**Reviewer:** [redacted]
**Follow Up Type:** *Document Submission*
**Follow Up Date:** *02/16/2025*

### 03/21/2025 Document Submission

**Submitted By:** [redacted]
**Date Submitted:** *02/10/2025*
**Reviewer:** [redacted]
**Follow Up Type:** *Not Required*

## 5a1 - DHS Access

### 1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

**Description of Violation**

*On 12/9/24 at approximately 10:30am, agents of the Department requested access to 5 different resident records; however, the records were not provided to the agents of the Department until the following times:*

- *At approximately 11:00am, resident-home contracts were received for the 6 residents*
- *At approximately 11:30am, additional documents were received for 3 of the residents*
- *At approximately 1:45pm, preadmission screenings were received for 2 residents*
- *At approximately 2:00pm, additional documents were received for 2 more residents*

*Agents of the Department also requested resident #2's record on 12/9/24 at approximately 10:30am; however, resident #2's record was not provided to the agents of the Department until the morning of 12/10/24.*

*REPEAT VIOLATION: 1/3/2023, et. al.*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*A whole house audit is being conducted by the health information specialist to assure that all resident records are complete, organized and easily located in the EMR. Date 2/3/25*

*Root cause identified that not all records were being consistently uploaded according to facility policy.*

*Resident records will continue to be uploaded and labeled according to policy by the nursing department.*

*Licensed Nursing staff has received education by the DON/Administrator/designee on policies of the EMR, including being able to easily locate specific resident documents and the need to comply with requirement 2600, 5a. Date: 1/13/2025*

*Random Audits of 10% of resident records will be conducted by the administrator/designee monthly x3 months and reported at the next QA meeting including a review of all items specified in 2600.26b with documentation of the review kept by the facility administrator 1/22/25 (DIRECTED: The monthly audits shall begin on 2/1/25. 1/17/25)*
*The administrator will ensure all requests for resident records are provided immediately upon request. Administrator will in-service support staff of need to comply with requirement 2600, 5a. (DIRECTED: The education shall be completed by 1/31/25. Documentation of the education shall be kept in accordance with 2600.65i. 1/17/25).*
*All resident documents will be scanned into resident EMR by nursing in a timely manner and in accordance to facility policy. Nursing will be educated on scanning documents into the EMR system within 30 days of the accepted plan of correction. (DIRECTED: The education shall be completed by 2/16/25. Documentation of the staff education shall be kept in accordance with 2600.65i. 1/17/25).*
*All resident documents will be maintained in the EMR system including: Resident face sheet, original Pre-Assessment, LOC assessment, DME, RASPS and Inventory Sheet, and activity choice.*

## 5a1 - DHS Access (continued)

*Audits will be conducted by the administrator/designee that all documents are complete and randomly monthly x3 months. (DIRECTED: The monthly audits shall begin on 2/1/25. ■ 1/17/25)*
*Audits will be reviewed at quarterly QA meeting which is scheduled on January 22, 2025. Audit documents will be attached to the meeting notes. QA review will include all items specified in 2600.5a.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/16/2025*

***Implemented (■ - 03/21/2025)***

## 65d - Initial Direct Care Training

**2. Requirements**

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

**Description of Violation**

*Direct care staff person A was hired on ■; however, has not successfully completed and passed the Department-approved direct care training course and passed the competency test.*

*REPEAT VIOLATION: 1/3/2023, et. al.*

**Plan of Correction** ***Directed (■ - 01/17/2025)***

*staff person A completed the Department-approved direct care training course 11/11/2023. (DIRECTED: Documentation of staff person A's successful completion of the Department-approved direct care competency course shall be kept in staff person A's record. ■ 1/17/25).*

*HR will ensure timely completion of the direct care training course at the time of hire and document on the new hire checklist which will also be verified by the administrator on the first day of employment. (DIRECTED: The new hire checklist shall be implemented by 2/1/25. Copies of completed checklists shall be kept in each staff person's record. All staff persons involved in the hiring process shall be educated on the new hire checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. ■ 1/17/25).*

*The HR Recruitment specialist will conduct an audit of all current direct care staff records to ensure compliance of all items specified in 2600.26b*
*Date: 2/3/25*

*HR will conduct an audit once per quarter of 10% of all new hire employee files to comply with regulation of 2600.65d. audit began 12/31/2024 for 4th quarter. 3/31/2025*

## 65d - Initial Direct Care Training (continued)

*Audit results will be reviewed during quarterly QA meetings and will include a review of all items specified in 2600.26b. QA review will include all items specified in 2600.65d. Documentation of the review will be kept.by the administrator. 1/22/2025.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/03/2025*

***Implemented ( - 03/21/2025)***

## 65f - Training Topics

**3. Requirements**

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
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.

**Description of Violation**

*Direct Care Staff Person B, hired on , did not receive training on the following topics during the 2023 training year:*

- *Medication self-administration training*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*2600.65f for training topics shall include the following: Medication self-administration training, instructions on meeting the needs of the residents as described by the pre admissions form, assessment tool, medical evaluation and support plan.*
*Care for residents with cognitive impairments, Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.*
*Personal care service needs by the residents, safe management techniques, care for residence with mental illness or mental retardation or both if the population is served in the home.*

*On 12/9/24 staff person B was pulled from the schedule. On 12/10/24 train the trainer educator enrolled staff person B into the approved on line services to complete medication self-administration training. Certificate was obtained 12/23/24 for staff person B.*
*Infection control training was completed on line through Relias. (DIRECTED: By 2/1/25: Staff person B shall receive education on Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration. Documentation of the education shall be kept in accordance with 2600.65i. 1/17/25).*

## 65f - Training Topics (continued)

*Within 30 calendar days of receipt of the accepted plan of correction: The Train the trainer or designated staff person shall audit all medication staff persons who are certified to pass medication for the team, weekly x4 weeks and ongoing.*
*Effective immediately the train the trainer on our team will keep copies of all staff with the medication certificate and monitor when they will be due to renew their license and MAR and medication review.*

*DIRECTED: Beginning on 2/1/25: Human Resources/designee shall review all training documents and the home's staff training plan on a monthly basis to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. The monthly reviews shall also ensure documentation of all staff education is kept in accordance with 2600.65i. ██ 1/17/25).*

*Audits will be reviewed at the next quarterly QA meeting scheduled on January 22, 2025. Documentation will be kept with the QA notes. QA review will include a review of 2600.65f*

*Licensee's Proposed Overall Completion Date: 1/29/2025*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/16/2025*

***Implemented (██ - 03/21/2025)***

## 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.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

**Description of Violation**

*Direct care staff Person B, hired on ██ did not receive training on the following topics during the 2023 training year:*
- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*
- *Resident rights*
- *The Older Adult Protective Services Act*
- *Falls and accident prevention*

*Staff Person C, hired on ██ did not receive training on the following topics during the 2023 training year:*

## *65g - Annual Training Content (continued)*

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations*
- *Resident rights*
- *The Older Adult Protective Services Act*
- *Falls and accident prevention*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*Direct care staff persons, ancillary staff persons, substitute personnel and regular scheduled staff personnel shall be trained annually in the following area:*
*Fire safety completed by a fire safety expert or by a staff person trained by a fire expert.*
*Emergency preparedness procedures in recognition in response to crisis and emergency situations.*
*Resident rights*
*Older Adult Protective Service act*
*Falls and accident prevention*
*New population groups in the home that were not previously served.*

*Direct care staff person B hired on  did not receive training on topics during the 2023 training year. Fire safety by a fire safety expert or by a trained fire safety expert. Emergency preparedness procedures and recognition and response to crisis and emergency situations. Resident Rights. Older Adult Protective Service Act. Falls and Accident prevention.*

*Direct care staff person C hired on did not receive training on topics during the 2023 training year. Fire safety by a fire safety expert or by a trained fire safety expert. Emergency preparedness procedures and recognition and response to crisis and emergency situations. Resident Rights. Older Adult Protective Service Act. Falls and Accident prevention.*

*Direct care staff person B hired on  Direct care staff person C hired on  they received on line Relias education. (DIRECTED: By 2/1/25: The administrator shall ensure direct care staff persons B and C have received training on all topics specified in 2600.65g and that documentation of each training is kept in accordance with 2600.65i.  1/17/25).*

*The HR/administrator/designee will conduct monthly audits to monitor completeness of assigned trainings to confirm compliance of all direct care workers with 2600.65g to ensure new hires annually training is completed to meet this regulation. (DIRECTED: Beginning on 2/1/25: Human Resources/designee shall review all training documents and the home's staff training plan on a monthly basis to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. The monthly reviews shall also ensure documentation of all staff education is kept in accordance with 2600.65i.  1/17/25).*

*Audits will be reviewed at the next quarterly QA meetings. Documentation will be kept with the QA notes. QA review will include all items specified in 2600.65g.*
*Licensee's Proposed Overall Completion Date will be throughout the year 2025 and annually.*

*Proposed Overall Completion Date: 01/13/2025*

## 65g - Annual Training Content *(continued)*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 103g - Storing Food

**5. Requirements**

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

**Description of Violation**

*On 12/9/24 at 10:14am, there was an open and unsealed tray of rice in the main kitchen's walk-in cooler.*

*On 12/9/24 at 10:25am, there were numerous open and unsealed bags of food in the True brand standing freezer, to include the following:*

- *A bag of tater tots, approximately 1/2 full*
- *A bag of french fries, approximately 1/2 full*
- *A bag of chicken breast fillets, approximately 1/2 full*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Please include documentation of the staff education will be kept in accordance with 2600.65i.*
*When is the home's next QM meeting? Please include completion date in POC which is within the next 30 calendar days. Also, please include the QM review will include a review of all items specified in 2600.26b and that documentation of the review will be kept.*
*Plan of Correction*
*the lead Chef immediately stored the cooled uncovered items properly in a sealed labeled storage container in the upright freezer. 12/9/2024*

*The lead chef re-educated his line staff team on labeling and storage technique in accordance with 2600.65i. 12/20/2024*

*Daily inspections will continue to assure all foods have the proper labeling and sealed containers and will continue the next 30 days. 12/10/2024 (DIRECTED: Immediately following the daily audits, the lead chef/designee shall audit all food storage areas weekly to ensure compliance with 2600.103g. █ 1/17/25).*

*Audits of daily inspections will be reviewed at the next quarterly QA meeting and will include a review of all items specified in 2600.26b . Documentation of the review will be kept.by the administrator.*
*1/22/2025.*
*QA review will include all items specified in 2600.103g.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *01/22/2025*

***Implemented (█ - 03/21/2025)***

## 121a - Unobstructed Egress

**6. Requirements**

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**Description of Violation**

*On 12/9/24 at approximately 10:50am, the following emergency exit doors were locked with keypads. These areas are not part of the home's secured dementia care unit (SDCU):*

- *The exit door to stairwell #1, which is located next to bedroom #209 on the 2nd floor*
- *The exit door to stairwell #2, which is located across from bedroom #223 on the 2nd floor*
- *The exit door to stairwell #1, which is located next to bedroom #309 on the 3rd floor*
- *The exit door to stairwell #2, which is located across from bedroom #323 on the 3rd floor*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*The building manager adjusted the magnetic locks to the stairwell doors and were disabled*
*An inspection was conducted by the building manager of all other doors to ensure they are unlocked and unobstructed*
*Monthly Audits will be conducted by the building manger/designee and include a check of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are unlocked and unobstructed. Audits will be turned into administrator and reviewed for compliance of 2600.26b. 1/22/2025 (DIRECTED: The monthly audits shall begin on 1/22/25 and shall include an inspection of all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to ensure they are all unlocked and unobstructed. 1/17/25).*
*Audits will be reviewed at the quarterly QA meeting and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator. 1/22/2025.*
*QA review will include all items specified in 2600.121a.*
*Overall completion date will be monitored on going.*

*DIRECTED: By 2/1/25: All staff persons shall be educated that all stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Documentation of the staff education shall be kept in accordance with 2600.65i. 1/17/25.*

*Proposed Overall Completion Date: 01/22/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented ( - 03/21/2025)***

## 123b - Emergency Procedures Posted

**7. Requirements**

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

## 123b - Emergency Procedures Posted *(continued)*

**Description of Violation**

*On 12/9/24, the emergency preparedness plans for the municipality in which the home is located were not posted in a conspicuous and public place in the home.*

*REPEAT VIOLATION: 1/3/2023, et. al.*

**Plan of Correction** ***Accept (█ - 01/17/2025)***

*The emergency preparedness plan for the municipality was posted: date:1/15/25*

*Staff was educated on location of plans by 12/20/24*

*PC director will conduct monthly audits that plans are posted in a conspicuous location 2/3/2025*

*Audits will be reviewed at the quarterly QA meeting and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator. 1/22/2025. QA review will include all items specified in 2600.123b.*

*Proposed Overall Completion Date: 01/13/2025*

**Licensee's Proposed Overall Completion Date:** *01/13/2025*

***Implemented (█ - 03/21/2025)***

## 130h - Inoperable Smoke Detector

**8. Requirements**

2600.
130.h. The home’s emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

**Description of Violation**

*The home's emergency procedures do not include what procedures will be immediately implemented if a smoke detector or fire alarm become inoperable.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*The homes Fire Watch policy was updated to include any inoperable smoke detectors would initiate a fire watch until the detectors were back on line. This would include hourly documented walk through s until the unit is operable. 12/11/2024*

*The EVS Director re-educated the department on the policy updates 12/11/2024*

*Monthly Audits by the EVS director will be reviewed at quarterly QA meetings and monthly safety meetings and will include a review of all items specified in 2600.26b. (DIRECTED: The monthly audits shall begin on 2/1/25. █ 1/17/25).*

## *130h - Inoperable Smoke Detector (continued)*

*QA meeting is scheduled on January 22, 2025. Documentation will be kept with the QA notes. QA review will include all items specified in 2600.130h.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 132b - Safety Inspection/Fire Drill

**9. Requirements**

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**Description of Violation**

*The most recent fire drill observed by a fire safety expert was conducted on 5/10/23.*

*REPEAT VIOLATION: 1/3/2023, et. al.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*EVS Director scheduled an observed fire drill from the safety expert for Scott Township 1/14/2025. See results attached. (DIRECTED: Documentation of the observed fire drill conducted by a fire safety expert shall be kept. █ 1/17/25).*

*Steps to ensure timely completion of supervised fire drills and fire safety inspections by a fire safety expert, will include a review monthly and every 6 months by the EVS director and the safety committee to schedule the observation for the following year to maintain compliance with 2600 132 b 1/10/2025*

*Monthly fire drill audits will continue to be reviewed at the monthly safety meeting and identify any concerns by the safety manager which will be reported by the administrator at quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator.*
*1/22/2025. QA review will include all items specified in 2600.132b.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *01/22/2025*

***Implemented (█ - 03/21/2025)***

## 132d - Evacuation

**10. 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.

## 132d Evacuation *(continued)*

**Description of Violation**

*According to the most recent documentation from a fire safety expert, dated 4/15/24, the maximum evacuation time to the home's fire safe areas on the 2nd and 3rd floors of personal care is 7 minutes, 50 seconds. However, the evacuation time during the following fire drills exceeded 7 minutes, 50 seconds:*

- *On 9/30/24 at 6:14am, the evacuation time was 9 minutes, 59 seconds*
- *On 8/26/24 at 11:50am, the evacuation time was 7 minutes, 57 seconds*
- *On 7/26/24 at 6:54pm, the evacuation time was 7 minutes, 57 seconds*
- *On 5/17/24 at 1:25pm, the evacuation time was 8 minutes, 54 seconds*

*According to the most recent documentation from a fire safety expert, dated 4/15/24, the maximum evacuation time to the home's fire safe areas in the home's SDCU is 4 minutes, 32 seconds. However, the evacuation time during the following fire drills exceeded 4 minutes, 32 seconds:*

- *On 11/19/24 at 6:28am, the evacuation time was 5 minutes, 16 seconds*
- *On 10/21/24 at 6:41pm, the evacuation time was 6 minutes, 33 seconds*
- *On 9/17/24 at 2:04pm, the evacuation time was 7 minutes, 1 second*
- *On 8/28/24 at 11:51pm, the evacuation time was 8 minutes, 43 seconds*
- *On 7/26/24 at 6:36pm, the evacuation time was 4 minutes, 36 seconds*
- *On 6/28/24 at 1:39pm, the evacuation time was 5 minutes, 18 seconds*
- *On 5/23/24 at 11:16pm, the evacuation time was 7 minutes, 46 seconds*

*According to the most recent documentation from a fire safety expert, dated 4/15/24, both the personal care areas and the home's SDCU have fire safe areas; however, the documentation does not indicate the specific areas that are fire safe. Both letters indicate the fire safe areas are located "beyond the fire doors"; however, do not indicate the specific location of the fire doors or the specific areas that are fire safe.*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*EVS Director scheduled an observed fire drill from the safety expert for Scott Township to provide training to the safety manager and administrator on fire safe areas of each unit and to determine the evacuation times of each unit and fire safe areas of each unit 1/14/2025*
*Evacuation times to the fire safe areas of the PC sections and dementia unit will be reviewed to determine the evacuation time of the Personal Care and Memory Support units and any updates to these times identified in writing and reviewed with the safety manager, administrator and*
*staff. 1/14/2025*

*Staff Education will be provided to the appropriate personnel regarding 132 d within 30 days of recommendations, by our safety manager of evacuation times and fire safe areas by the fire safety manager/designee and administrator. 2/14/2025 (DIRECTED: By 2/14/25: All staff persons shall be re educated on the home's fire drill evacuation procedures, which includes the location of all current fire safe areas. Documentation of the staff education shall be kept in accordance with 2600.65i. 1/17/25).*

## 132d - Evacuation (continued)

*Monthly fire drill audits will be conducted by the safety manager/designee monthly and at 6 months, ongoing to ensure all residents evacuate within the time specified by the fire safety expert. Audits will be reviewed by the administrator that recommendations are being followed. (DIRECTED: Beginning on 2/1/25: The administrator shall review all fire drill records monthly to ensure all residents evacuate 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. If residents are unable to evacuate to the fire-safe areas within the specified time, the administrator shall immediately review the root cause for the delay and immediately implement corrective action, which may include increasing staffing in accordance with 2600.60a. Documentation of the monthly review of the fire drill records shall be kept for 6 months. ██ 1/17/25).*

*DIRECTED: By 2/1/25: The home shall obtain documentation from a fire safety expert which indicates the specific location of all fire-safe areas in the home. Documentation shall be kept. ██ 1/17/25).*

*Audits will be reviewed monthly at safety committee meetings and reported at quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator. 1/22/2025. QA review will include all items specified in 2600.132d.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/14/2025*

***Implemented (██ - 03/21/2025)***

## 141b1 - Annual Medical Evaluation

**11. 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 was completed on ██.*

**Plan of Correction** ***Directed (██ - 01/17/2025)***

*Resident #2 received a new medical evaluation from their physician on 1/16/25 was received from the MD by our ██ LPN. (DIRECTED: By 1/20/25: The administrator shall ensure resident #2's new medical evaluation is present in resident #2's record. ██ 1/17/25).*

*An audit of all resident medical evaluation dates will be conducted by a designated RN. To ensure all residents are in compliance with 141.b1. and schedule any needed evaluations. 2/3/2025*

*A spreadsheet was established as a tracking system used to identify all residents and their current medical evaluation dates. date 2/3/2025*

*The tracking system shall be reviewed and updated monthly by the LPN date 2/3/2025 (DIRECTED: All LPN's involved in medical evaluation reviews shall be educated on the new tracking system and the monthly reviews of the tracking system. Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 1/17/25).*

## 141b1 - Annual Medical Evaluation (continued)

*Monthly audits will be conducted by the administrator/designee that all medical evaluations are in compliance of 141.b1 and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.141b1.*
*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/03/2025*

***Implemented ( - 03/21/2025)***

## 171b5 - First Aid Kit

**12. Requirements**

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

**Description of Violation**

*On 12/10/24, the first aid kits in both of the home's Chrysler 300 Touring cars, which are used to transport residents, did not include the following items:*

- *Eye coverings*
- *A thermometer*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*All vehicles first aide kits were confirmed to have all contents as specified in 2600.96 (relating to first aid kit). on 12/11/2024*

*Transportation Director was educated on the regulation 171.b.5 by administrator on 12/11/2024 (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 1/17/25).*

*Monthly audits will be conducted by the transportation Director/Designee that all components of the first aid kits are present to be in compliance with 171.b5 . (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: Beginning on 2/1/25: The transportation director/designee shall inspect all of the home's vehicles monthly to ensure a first aid kit, which contains all items specified in 2600.96a, is present in each vehicle. 1/17/25).*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator 1/22/2025*
*QA review will include all items specified in 2600.171b.*

*Proposed Overall Completion Date: 01/13/2025*

## 171b5 - First Aid Kit *(continued)*

**Directed Completion Date:** *02/01/2025*

***Implemented ( - 03/21/2025)***

## 183b - Meds and Syringes Locked

**13. Requirements**

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

*On 12/10/24 at 11:35am, a tube of Menthol Zinc Oxide ointment was unlocked, unattended and accessible in resident #3's bedroom, which is located in the home's SDCU.*

**Plan of Correction** ***Accept ( - 01/17/2025)***

*The medication was removed from resident #3's bedroom and placed in medication cart. 12/10/2024*

*Licensed nursing and Medical tech Staff certified to administer medications were. re-educated on Medication Administration policies and that medications are properly stored/locked in medication cart at all times. Documentation of the staff education will be kept in accordance with 2600.65i. 12/20/2024*

*Weekly audits will be conducted by LPN/Med Tech and include all PC and MS rooms. Nursing staff will complete the house audit weekly for 4 weeks to comply with the requirement 2600. 183.b. 12/23/2024*

*Monthly audits will be conducted by LPN/Med Tech and include all PC and MS rooms x 3 months. 3/31/2025*

*Upon completion of the weekly audits, monthly audits will continue monthly x3 months by the pharmacy consultant to comply with the requirement 2600. 183.b. /20/2025*
*Direct care staff person B hired on*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.183b. Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Licensee's Proposed Overall Completion Date:** *01/22/2025*

***Implemented ( - 03/21/2025)***

## 183f - Discontinued Medications

**14. Requirements**

2600.

## 183f - Discontinued Medications *(continued)*

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

**Description of Violation**

*On 12/10/24, the following open and expired medications belonging to resident #5 were present in the home's medication cart:*

- *A bottle of Polyethylene Glycol, which expired in 3/2024*
- *A bottle of Milk of Magnesia, which expired in 11/2024*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*The expired bottle of Polyethylene Glycol, and Milk of Magnesia were immediately disposed of. 2/10/2024 (DIRECTED: Resident #5's expired medications were removed from the medication cart on 12/10/24. 1/17/24).*
*Licensed nursing and Medical tech Staff certified to administer medications were. re-educated on Medication Administration policies and to dispose of any expired medications according to facility policy by the DON. Documentation of the staff education will be kept in accordance with 2600.65i. 12/20/2024*
*A house audit was conducted by the pharmacy consultant to ensure no expired medications are present in the home. 12/20/2024*
*Weekly audits will be conducted by the nursing /med tech/designee to confirm there no expired medications in the home x4 weeks. 12/10/24 (DIRECTED: The weekly audits shall include a review of at least 7 different resident's medications during each audit to ensure no expired or discontinued medications are present in the home. Documentation of the weekly audits shall be kept for 2 months. 1/17/25).*

*The Pharmacy nurse consultant will conduct monthly audits (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue indefinitely and shall include a review of at least 7 different resident's medications during each monthly audit to ensure no expired or discontinued medications are present in the home. 1/17/25). with reports to administrator that no expired medications are in the house to comply with 183.f. 1/29/2025 (DIRECTED: The monthly audits shall include a review of at least 7 different resident's medications to ensure no expired or discontinued medications are present in the home. 1/17/25).*
*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b Quality management regulation. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings. QA review will include all items specified in 2600.184f.*
*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented ( - 03/21/2025)***

## 184a - Resident's Meds Labeled

**15. Requirements**

2600.

## 184a - Resident's Meds Labeled *(continued)*

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**

*On 12/10/24, the pharmacy label for resident #1's Doxepin HCL-50mg capsule indicates to "Administer 1 capsule via gastric tube at bedtime"; however, resident #1 does not have a gastric tube and is taking the medication orally.*

*On 12/10/24, there were 2 bottles of Hyoscyamine-0.125mg tablets on the medication cart belonging to resident #1. One bottle had a pharmacy label indicating to "Take 1 tablet by mouth every 4 hours as needed"; however, the other bottle had a pharmacy label indicating to "Dissolve 1 tablet under the tongue every 4 hours as needed". Resident #1 is currently prescribed to take this medication orally every 4 hours as needed.*

*On 12/10/24, there were 2 bottles of Acetaminophen-500mg tablets on the medication cart belonging to resident #1. One bottle had a pharmacy label indicating to "Take 1 tablet by mouth every 4 hours as needed'; however, the other bottle had a pharmacy label indicating to "Take 2 tablets by mouth every 8 hours as needed'. Resident #1 is currently prescribed to take 1 tablet by mouth every 4 hours as needed.*

*Resident #1 is currently prescribed Lorazepam 0.5mg tablet-Take 1 tablet by mouth every 4 hours as needed. On 12/10/24, there were 2 prescriptions of Lorazepam-0.5mg tablets on the medication cart belonging to resident #1; however, the pharmacy label for 1 of the medications indicated "Lorazepam 0.5mg tablet-Take 1 tablet every 6 hours as needed".*

*On 12/10/24, there were 2 vials of Morphine Sulfate-20mg/1ml on the medication cart belonging to resident #1. One vial had a pharmacy label indicating to "Take 0.25ml sublingually every hour as needed for shortness of breath"; however, the other vial had a pharmacy label indicating to "Take 0.25ml by mouth every 3 hours as needed for shortness of breath". Resident #1 is currently prescribed to take 0.25ml by mouth every hour as needed for shortness of breath.*

*Resident #4 is prescribed Novolog 100u/ml insulin-Administer 2 units subcutaneously before meals, as well as sliding scale coverage before meals and at bedtime in accordance with the following sliding scale: less than 70, call MD; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-400=6 units; If BS are greater than 400, call MD. However, on 12/10/24, the sliding scale dosage instructions were not present on resident #4's Novolog pharmacy label.*

*REPEAT VIOLATION: 1/3/2023, et. al.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Resident #1*

*Doxepin HCL-50mg capsule order was changed to oral administration on: date: 12/10/2024*
*By Designee LPN*

*Hyoscyamine-0.125mg tablets order was confirmed to be taken orally q 4 hrs PRN*
*Date 12/10/2024*

*By: DON*

184a Resident's Meds Labeled (continued)

(The 2nd bottle was discarded according to policy) date 12/10/2024
By DON
Acetaminophen 500mg tablets as clarified to be given 1 tab orally every 4 hours PRN
Date 12/10/2024
By Memory Support LPN
(The 2nd bottle discarded by ██ LPN on12/10/2024 date)
Lorazepam 0.5mg tablet order confirmed q 4 hrs prn 12/10/2024 by the ██ LPN.
(2nd card label direction was changed 12/10/2024 by ██ LPN

Resident #4 Novolog 100u/ml insulin sliding scale order was clarified and labeled on 12/10/2024 by DON.

DIRECTED: By 1/22/25: The Director of Nursing/designee shall review all medications for residents #1 and #4 to ensure accurate and complete pharmacy labels are present on each medication in accordance with 2600.184a and in accordance current prescribers' orders. ██ 1/17/25.

The pharmacy manager at Symbria was educated that each sliding scale instructions must be on the label on 12/10/2024 by DON.

Licensed nursing and med tech Staff were educated by the DON on medication labels for all residents, new orders to comply with requirement 2600.184.a. Documentation of the staff education will be kept in accordance with 2600.65i. 12/20/2024

Daily audits by the 11 7 LPN that all new medication orders and received prescriptions match the pharmacy label including the correct dosage frequency, and route 12/20/2024

Weekly audit will be conducted by the nurse/Med Tech to confirm that EMAR orders exactly matches the label x4 weeks. 12/10/2024 (DIRECTED: The weekly audits shall include a review of at least 7 different resident's medications during each audit to ensure each medication has a current and complete pharmacy label present in accordance with 2600.184a and in accordance current prescribers' orders. Documentation of the weekly audits shall be kept for 2 months. ██ 1/17/25).

Monthly audits will continue ██ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue indefinitely and shall include a review of at least 7 different resident's medications during each monthly audit to ensure each medication has a current and complete pharmacy label present in accordance with 2600.184a and in accordance current prescribers' orders ██ 1/17/25) by the nurse/med tech to confirm that EMAR orders exactly matches the label. 3/31/2025

Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.184a. Overall completion date will be on going.

Proposed Overall Completion Date: 01/13/2025

## 184a - Resident's Meds Labeled *(continued)*

**Directed Completion Date:** *02/01/2025*

***Implemented ( - 03/21/2025)***

## 185a - Implement Storage Procedures

**16. 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 Albuterol Sulfate inhaler 90mcg-Take 2 puffs by mouth 4 times daily; however, on 12/10/24, this medication was not present in the home and available for administration.*

*Resident #2 is prescribed Calazyme cream-Apply to buttocks as needed after each episode of incontinence; however, on 12/10/24, the cream was not present in the home and available for administration.*

*Resident #4 is prescribed blood sugar readings before meals. On 12/5/24 at 9:59pm, resident #4's glucometer indicated a blood sugar reading of 156; however, this reading was not documented on resident #4's December 2024 medication administration record (MAR).*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*Resident #2 albuterol inhaler and calazyme were delivered to the home on 12/10/2024*
*Resident #4 Blood sugar reading was not documented on 12/5/24 medication record.*

*Nursing and Med Techs were educated by the DON on policy for safe storage procedures, access and distribution of medications and timely documentation of blood sugar readings correctly on the MAR.*
*12/23/2024 (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. 1/17/25).*

*Weekly audit will be conducted by the 11-7 nurse/Med Tech to confirm that all medications are available and timely documentation of blood sugar readings correctly on the MAR when checking glucometers nightly x4 weeks. 12/10/2024 (DIRECTED: The weekly audits shall include a review of at least 7 different resident's medications during each audit to ensure all current prescribed medications are present in the home and to ensure accurate and complete blood sugar documentation is present on each resident's MAR. Documentation of the weekly audits shall be kept for 2 months. 1/17/25).*

*Monthly audits will continue (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. The monthly audits shall continue indefinitely and shall include a review of at least 7 different resident's medications during each monthly audit to ensure all current prescribed medications are present in the home and to ensure accurate and complete blood sugar documentation is present on each resident's MAR. 1/17/25) by the nurse/med tech to confirm safe storage procedures, access and distribution of medications and timely documentation of blood sugar readings are meeting the regulation 185.a. 3/31/2025*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.185a.*

## *185a - Implement Storage Procedures (continued)*

*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 187a - Medication Record

**17. Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
7. Route of administration.
8. Frequency of administration.

**Description of Violation**

*On 12/10/24, resident #1's December 2024 MAR indicated "Doxepin HCL 50mg capsule-Administer 1 capsule via gastric tube at bedtime"; however, resident #1 does not have a gastric tube and is taking the medication orally.*

*On 12/10/24, resident #1's December 2024 MAR indicated "Mag AL Plus-Take 30 ml orally as needed" however, does not include the frequency of the medication administration.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Resident #1*

*Doxepin HCL 50mg capsule-order was updated to be taken orally on 12/10/2024 by LPN*

*Mag AL Plus-Take 30 ml orally as needed updated to include the frequency of every 4 hours on on 12/10/2024 by LPN.*

*Staff was educated by the DON on medication records that each medication contains the right route and the right frequency. Documentation of staff education will be kept in accordance with 2600.65i*
*12/20/2024*

*Daily audit of new orders will be conducted by 11p-7a for all residents by the LPN/Med Tech to confirm that correct labeling of all prescribed medication includes dosage frequency, route to match the physician order.* *12/23/24*

*DIRECTED: Beginning on 1/20/25: The Director of Nursing/designee shall review the current MAR's of at least 7 different residents weekly x 4 months then monthly thereafter to ensure each resident has an accurate and complete MAR present in accordance with 2600.187a and in accordance with prescribers' orders. Documentation of the weekly audits shall be kept for 2 months. █ 1/17/25*

## 187a - Medication Record (continued)

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.187a.*

*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 190a - Completion Medication Course

**18. Requirements**

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Direct care staff person B has not successfully completed the Department-approved medication administration course; however, has administered medications to numerous residents on numerous dates/times, to include the administration of the following medications to resident #5 of the evenings of 12/1/24, 12/2/24 and 12/6/24:*

- *Melatonin-3mg tablet*
- *Memantine HCL-10mg tablet*
- *Donepezil HCL-23mg tablet*

*Direct care staff person D has not successfully completed the Department-approved medication administration course; however, has administered medications to numerous residents on numerous dates/times, to include the administration of Levothyroxine-100mcg tablet to resident #4 on the mornings of 12/6/24 and 12/7/24.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Direct care staff person B successfully completed the department approved medication administration course with MAR reviews and medication observations by a train the trainer 12/23/2024 (DIRECTED: Documentation of direct care staff person B's successful completion of the Department-approved medication administration course shall be kept in direct care staff person B's record. █ 1/17/25).*

*Direct care staff person D successfully completed the department approved medication administration with MAR reviews and medication observations by a train the trainer course on 12/26/2024 (DIRECTED: Documentation of direct care staff person D's successful completion of the Department-approved medication administration course shall be kept in direct care staff person D's record. █ 1/17/25).*

*An audit of all med techs was completed by DON 12/11/2024*

## *190a - Completion Medication Course (continued)*

*HR has implemented a tracking system via ADP which includes the names of all med techs, the date of their initial passing as well as the dates of their quarterly observations throughout the year. The tracking system shall be reviewed and updated monthly and reports to the administrator upcoming observations due.*
*completion date and person responsible. (DIRECTED: The monthly audits of the tracking system shall begin on 2/1/25 and shall be conducted by Human Resources/designee. Documentation of the tracking system shall be kept. ██ 1/17/25).*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.190a.*
*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (██ - 03/21/2025)***

## 190b - Insulin Injections

**19. Requirements**

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

**Description of Violation**

*Direct care staff person B has not successfully completed the Department-approved medication administration course or successfully completed the Department-approved diabetes patient education program within the past 12 months; however, direct care staff person B has administered insulin to numerous residents on numerous dates/times, to include the administration of Novolog 100u/ml to resident #4 on the evenings of 12/2/24 and 12/6/24.*

**Plan of Correction** ***Directed (██ - 01/17/2025)***

*Direct care staff person B completed Diabetic training conducted by a certified diabetic educator (CDE) Date 1/15/25 by CDE (DIRECTED: Documentation of direct care staff person B's successful completion of the Department-approved medication administration course and successful completion of the Department-approved diabetes patient education program conducted by a Certified Diabetic Educator shall be kept in direct care staff person B's record. ██ 1/17/25).*

*an audit of all direct care staff completed diabetic training was completed.*

## *190b - Insulin Injections (continued)*

*The home shall develop and implement a tracking system which includes the names of all med techs and the date each med tech successfully received diabetic education from a CDE. The tracking system shall be reviewed and updated quarterly and reports reviewed by the administrator. (DIRECTED: By 2/1/25: Human Resources/designee shall develop and implement a tracking system which includes the names of all med techs and the date each med tech successfully completed the Department-approved diabetes patient education program conducted by a Certified Diabetic Educator. The tracking system shall be reviewed and updated quarterly by Human Resources/designee, beginning on 2/1/25. Documentation of the tracking system shall be kept. █ 1/17/25).*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025*

*a review to ensure med techs received diabetic education from a CDE*
*When was the audit conducted and who conducted it? Also, the audit should include a review to ensure med techs received diabetic education from a CDE, not just successful completion of the medications course. Please amend POC step.*
*Staff person D is not part of this violation, so please remove steps from POC.*
*The home shall develop and implement a tracking system which includes the names of all med techs and the date each med tech successfully received diabetic education from a CDE. The tracking system shall be reviewed and updated quarterly. Please add step to POC, including completion date and person responsible.*
*When is the home's next QM meeting? Please include completion date in POC which is within the next 30 calendar days. Also, please include the QM review will include a review of all items specified in 2600.26b and that documentation of the review will be kept. QA review will include all items specified in 2600.190b.*

*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 224a - Preadmission Screen Form

**20. 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**

*No preadmission screening was present for resident #1, who was admitted to the home on █*

*No preadmission screening was present for resident #3, who was admitted to the home on █*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Resident #1 Preadmission screen form completed on 12\23*

## 224a Preadmission Screen Form (continued)

*2024 by ██ LPN. (DIRECTED: By 1/20/25: The administrator shall ensure resident #1's preadmission screening is present in resident #1's record. ██ 1/17/25).*
*Resident #3 Preadmission screen form competed on 12/23/24 by ██ LPN (DIRECTED: By 1/20/25: The administrator shall ensure resident #3's preadmission screening is present in resident #3's record. ██ 1/17/25).*

*Staff education was provided by the administrator on 224.a. to licensed nursing staff responsible for completion of preadmission screenings 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 and will be maintained in the resident record under the Admission Tab in the EMR or chart and documentation of the staff education shall be kept in accordance with 2600.65i.*

*An audit will be completed by RN staff person to ensure all current resident records contain a preadmission screening by 2/3/2025*

*Audits will be completed monthly by the administrator/designee that all new admissions have a completed prescreen in their Admission Tab in the EMR electronic record and chart. 2/3/20025*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure timely preadmission screenings are completed for all new admissions in accordance with 2600.224a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. ██ 1/17/25*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.224a.*

*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/03/2025*

***Implemented (██ - 03/21/2025)***

## 225a - Assessment 15 Days

### 21. 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.

## 225a - Assessment 15 Days *(continued)*

**Description of Violation**

*Resident #1 is currently prescribed a mechanical soft diet; however, resident #1's assessment, dated [redacted] indicates resident #1 has no dietary needs. Also, resident #1 requires the assistance of 2 staff persons to transfer in/out of bed/wheelchair; however, resident #1's assessment indicates resident #1 is independent with transferring in/out of bed/wheelchair.*

*Resident #3 was admitted to the home's SDCU on [redacted]; however, resident #3's assessment was not completed until [redacted].*

*Resident #4 was admitted to the home on [redacted]; however, resident #4's assessment was completed until [redacted].*

**Plan of Correction** ***Directed ([redacted] - 01/17/2025)***

*Resident #1 verify diet and transfer status clarified and updated by [redacted] LPN on 12\23\2024 (DIRECTED: By 1/20/25: The administrator shall ensure resident #1's updated assessment is present in resident #1's record. [redacted] 1/17/25).*
*Resident #3 SDCU on [redacted]; however, resident #3's assessment was not completed until [redacted].*
*Resident #4 assessment was completed until [redacted].*
*225.a.*
*Licensed nursing staff received education by the administrator that all residents shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission, including the administrator/ designee, or a human service agency may complete the initial assessment. Documentation of the staff education shall be kept in accordance with 2600.65i.*

*A house audit was conducted by RN staff person to confirm an assessment is present for all residents and education for licensed nurses will be provided by RN.*
*Date: 12/18/24*

*Monthly audits will be conducted by the administrator/designee that each new resident has an assessment completed by day 15. 2/3/2025*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure timely assessments are completed for all new admissions in accordance with 2600.225a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025.*
*QA review will include all items specified in 2600.225a.*

*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

## 225a Assessment 15 Days *(continued)*

**Directed Completion Date:** *02/03/2025*

***Implemented (█ - 03/21/2025)***

## 225c - Additional Assessment

### 22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

**Description of Violation**

*Resident #2's most recent assessment was completed on █. Also, resident #2 is currently prescribed a mechanical soft diet; however, resident #2's most recent assessment, dated █, indicates a regular diet.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Resident #2s most recent assessment did not reflect a mechanical soft diet.*
*On 12/23/24 the assessment was updated to reflect accurate information. (DIRECTED: By 1/20/25: The administrator shall ensure resident #2's updated assessment is present in resident #2's record. █ 1/17/25).*
*Within 30 calendar days of receipt of this plan of correction the Administrator or designee shall develop and implement a new checklist to ensure initial assessments reflect the proper changes in condition of any resident.*
*Copies of the checklist will be kept in each residents chart and a binder created for internal use.*
*Within 30 days of receipt of this plan of correction all staff responsible for completion of resident assessments and support plans shall be reeducated on proper documentation of any changes in condition of resident within 5 calendar days of a new admission or significant change. (DIRECTED: Documentation of the staff education shall be kept. █ 1/17/25).*

*DIRECTED: By 2/10/25: The administrator/designee shall review all current resident records to ensure each resident has an accurate, complete and current assessment present. █ 1/17/25*

*DIRECTED: By 1/27/25: The administrator shall develop and implement a system to ensure resident assessments are updated as resident care needs change. Documentation of the system shall be kept. All staff persons involved in updating resident assessments shall be educated on the new system by 1/27/25. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 1/17/25).*

*Audits will be reviewed at the next quarterly QA meeting scheduled for January 22, 2025 and the audit documents will be kept with the QA meeting notes. QA review will include all items specified in 2600.225c*
*Overall completion date will be on going.*

*Proposed Overall Completion Date: 01/13/2025*

**Directed Completion Date:** *02/16/2025*

***Implemented (█ - 03/21/2025)***

## 227a - Support Plan 30 Days

**23. Requirements**

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

**Description of Violation**

*Resident #1 was admitted to the home on [redacted]; however, resident #1's support plan was not completed until [redacted]*

**Plan of Correction** ***Directed ([redacted] - 01/17/2025)***

*Resident #1 Support plan*
*227.a.*

*Licensed nursing staff received education by the administrator that a resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25).*
*The support plan shall be documented on the Department's support plan form and shall be kept in each resident's record.*
*A house audit was conducted by RN staff person to confirm an assessment is present for all residents.*
*Date: 12/15/24*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure timely support plans are completed for all new admissions in accordance with 2600.227a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25*

*DIRECTED: By 2/10/25: The administrator/designee shall review all current resident records to ensure each resident has an accurate, complete and current support plan present. [redacted] 1/17/25*

*Audits will be reviewed at the next quarterly QA meeting scheduled for January 22, 2025 and the audit documents will be kept with the QA meeting notes.*
*QA review will include all items specified in 2600.227a.*

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/10/2025*

***Implemented ([redacted] - 03/21/2025)***

## 227d - Support Plan Medical/Dental

**24. 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.

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

**Description of Violation**

*Resident #1 is currently receiving hospice services approximately 5 times per week; however, resident #1's most recent support plan, dated [redacted], does not include the hospice services or the frequency of hospice services resident #1 is receiving.*

*Resident #2 is currently receiving hospice services and uses a bed enabler for turning/positioning; however, resident #2's most recent support plan, dated [redacted], does not include the use of the bed enabler and does not include the hospice services or the frequency of hospice services resident #2 is receiving.*

*Resident #3 is currently receiving hospice services numerous times per week; however, resident #3's most recent support plan, dated [redacted], does not include the hospice services or frequency of hospice services resident #3 is receiving.*

**Plan of Correction** ***Directed ([redacted] - 01/17/2025)***

*Each home shall document in their resident support plan the medical and dental care, vision, hearing, mental health or other behavior health care services that shall be made available to the residents or referrals from the resident outside services if the residents physician or physicians assistant, certified nurse practitioner determine the necessity of these service. This requirement does not require a home to pay for the cost of these medical and behavioral care services.*
*Resident #1 receives hospice services 5x week but the most recent support plan did not reflect the change in services.*
*Resident #2 receives hospice services and uses a bed enabler, the most recent support plan did not include the bed enabler or the frequency of hospice services.*
*Resident #3 receives hospice services within the week but the most recent support plan does not include their services or the frequency.*

*Administrator or designee will provide education to all licensed nursing staff related to 2600 227d that all residents support plan includes other medical services suggested by the MD, PA, CRNP to determine the necessary services (such as hospice services). Updated support plans for Resident #1, #2 and resident #3 was completed by the LPN designee on January 15, 2025 for all staff to review. (DIRECTED: By 1/20/25: The administrator shall ensure the updated support plans for residents #1, #2 and #3 are present in each resident's record and are accessible to direct care staff persons at all times in accordance with 2600.227i. [redacted] 1/17/25).*
*Completion date within 3 months of the accepted plan of correction.*

*DIRECTED: By 2/10/25: The administrator/designee shall review all current resident records to ensure each resident has an accurate, complete and current support plan present. [redacted] 1/17/25*

*DIRECTED: By 1/27/25: The administrator shall develop and implement a system to ensure resident support plans are updated as resident care needs change. Documentation of the system shall be kept. All staff persons involved in updating resident support plans shall be educated on the new system by 1/27/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25).*

*Audits will be reviewed at Quarterly QA meetings and will include a review of all items specified in 2600.26b. Documentation of the review will be kept.by the administrator and reported at quarterly QA meetings 1/22/2025. QA review will include all items specified in 2600.227d.*

## 227d Support Plan Medical/Dental (continued)

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/10/2025*

***Implemented ( - 03/21/2025)***

## 227i - Support Plan Accessible

**25. Requirements**

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

**Description of Violation**

*Throughout the day on 12/9/24, support plans for numerous residents, to include resident #1, could not be located and were not accessible to direct care staff persons.*

**Plan of Correction** ***Directed ( - 01/17/2025)***

*12/29/24 support plans for numerous residents to include residents #1 could not be located and accessible for the direct care staff persons. Administrator or designee will ensure all documents are scanned into the Matrix system. (DIRECTED: By 1/20/25: The administrator shall ensure all direct care staff persons have access to the Matrix system. 1/17/25). A binder with resident face sheet, original pre assessment, level of care, DME, RASP, inventory sheet and activity choices will be available for all staff to review. (DIRECTED: By 1/20/25: The administrator shall ensure the binders are accessible to all direct care staff persons at all times and include the most recent support plan for each resident. 1/17/25). Updated copies of the support plans will be maintained by the nursing designee for all staff to have access to the support plans. Any updated information will be added to the support plan and the binder updated at that time.*
*Designee will ensure that proper documents are available either by EMR or by chart. (DIRECTED: This step shall be completed by 1/20/25 to ensure all current resident support plans are accessible to all direct care staff persons at all times. 1/17/25).*
*All staff will be educated on 2600.221i by a designee by January 29, 2025.*
*Audits will be reviewed at quarterly QA meeting which is scheduled January 22, 2025. Audit documentation will be kept with the meeting notes. QA review will include all items specified in 2600.227i.*
*Completion date within 3 months of the accepted plan of correction.*

*Proposed Overall Completion Date: 01/16/2025*

**Directed Completion Date:** *01/22/2025*

***Implemented ( - 03/21/2025)***

## 231b - Medical Evaluation

**26. Requirements**

2600.

## 231b Medical Evaluation *(continued)*

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 #3 was admitted to the home's SDCU on [redacted] however, resident #3's initial medical evaluation, dated [redacted], did not indicate a need for resident #3 to be served in the SDCU. An additional medical evaluation was completed for resident #3 on [redacted]; however, does not include a diagnosis of Alzheimer's disease or other dementia.*

**Plan of Correction** ***Directed ([redacted] - 01/17/2025)***

*On 12/23/24 the medical evaluation was updated to reflect the accuracy for Resident #3 reflecting the SDCU. (DIRECTED: By 1/20/25: The administrator shall ensure resident #3 has a current medical evaluation completed, which includes the need for resident #3 to be served in the home's SDCU and includes a diagnosis of Alzheimer's disease or other dementia. A copy of resident #3's current medical evaluation shall be placed in resident #3's record. [redacted] 1/17/25).*

*A house audit was conducted by [redacted] RN to confirm an medical evaluation is present for all residents and education for licensed nurses will be provided by RN.*
*Date:12/15/24*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure timely and complete medical evaluations are completed for all new SDCU admissions, which includes documentation of the resident's need to be served in the SDCU and includes a diagnosis of Alzheimer's disease or other dementia in accordance with 2600.231b. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25*

*Audits will be reviewed at the next quarterly QA meeting on January 22, 2025. Audit documents will be kept with the meeting notes. QA review will include all items specified in 2600.231b*

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented ([redacted] - 03/21/2025)***

## 231c - Preadmission Screening

**27. 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 transferred to the home's SDCU on [redacted] however, no cognitive preadmission screening was completed for resident #1.*

*Resident #3 was admitted to the home's SDCU on [redacted]; however, no cognitive preadmission screening was*

## 231c - Preadmission Screening (continued)

*completed for resident #3.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*No cognitive preadmission screening was present for resident #1 and resident #3.*

*DIRECTED: By 1/22/25: The administrator shall ensure cognitive preadmission screenings are completed for residents #1 and #3. Copies of the completed cognitive preadmission screenings shall be placed in residents #1 and #3's records. █ 1/17/25.*

*A house audit was conducted by █ RN to confirm an pre assessment is present for all residents and education for licensed nurses will be provided by RN.*
*Date:12/18/24*

*█ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. █ 1/17/25). the Administrator or designee shall develop and implement a new checklist to ensure timely completion of the preadmission screening. (DIRECTED: The administrator shall develop and implement a new admission checklist to ensure timely and complete cognitive preadmission screenings are completed for all new SDCU admissions in accordance with 2600.231c. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 1/17/25)*

*Copies of the checklist will be kept in each residents chart.*
*█ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. █ 1/17/25) all staff responsible for completion of cognitive preadmission screening shall be reeducated on proper documentation and the importance of completion in a timely manner.*
*Audits will be reviewed at the next quarterly QA meeting on January 22, 2025. Documents will be kept with QA meeting notes. QA review will include all items specified in 2600.231c.*

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (█ - 03/21/2025)***

## 231e - No Objection Statement

**28. 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 #1 transferred to the home's SDCU on █; however, resident #1 and resident #1's designated person did not sign the addendum indicating they have not objected to resident #1's admission to the SDCU until █.*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Resident #1 transfer to the SDU on █ however resident #1 and the resident #1 designee did not sign the addendum to transfer to the unit until █*

## 231e - No Objection Statement (continued)

*DIRECTED: By 1/22/25: The administrator shall ensure documentation is present in resident #1's record indicating resident #1 and resident #1's designated person have not objected to resident #1's transfer to the home's SDCU. █ 1/17/25*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure documentation is obtained at the time of all admissions/transfers to the home's SDCU which indicates the resident and the resident's designated person have not objected to the resident's admission/transfer to the home's SDCU. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. █ 1/17/25*

*DIRECTED: By 2/10/25: The administrator/designee shall review the records for all residents currently residing in the SDCU to ensure documentation is present indicating each resident and their designated person have not objected to the admission or transfer to the home's SDCU. █ 1/17/25*

*Administrator or designee will provide education to all staff on regulation 2600.231e. Administrator or designee will ensure each resident has signed the no objection statement to the SDU.*
*Within 30 calendar days of receipt of this plan of correction all staff who is responsible on transfers or admissions to the SDU shall ensure all admissions to the unit have the appropriate signatures in place.*
*Audits will be reviewed at the next quarterly QA meeting on January 22, 2025. Audit documents will be kept with the QA meeting notes. QA review will include all items specified in 2600.231e.*
*Completion date: January 29, 2025.*

*Proposed Overall Completion Date: 01/16/2025*

**Directed Completion Date:** *02/16/2025*

***Implemented (█ - 03/21/2025)***

## 234a - Admission Support Plan

### 29. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

**Description of Violation**

*Resident #1 transferred to the home's SDCU on █; however, resident #1's support plan was completed on █*

*Resident #3 was admitted to the home's SDCU on █; however, resident #3's support plan was not completed until █*

**Plan of Correction** ***Directed (█ - 01/17/2025)***

*Within 72 hrs of the admission or within 72 hrs prior to admission to the SDU shall be developed and implemented in the residents record.*
*On █ resident #1 transferred to SDU, however the resident #1 support plan was completed on █*

## *234a - Admission Support Plan (continued)*

*On [redacted] resident #3 was admitted to the SDU however resident #3 support plan was not completed until [redacted]*
*Violation due to untimely completion of SDU support plans of untimely submission.*
*On 12/23/24 LPN completed new care plan and DME for resident #1 and #3. Support plans will be reviewed, signed and copies given to respected families. (DIRECTED: By 1/20/25: The administrator shall ensure the current support plans for residents #1 and #3 are present in residents #1 and #3's records and are accessible to all direct care staff persons at all times in accordance with 2600.227i. [redacted] 1/17/25).*

*DIRECTED: By 2/1/25: The administrator shall develop and implement a new admission checklist to ensure timely and complete resident support plans are completed for all SDCU admissions in accordance with 2600.234a. Copies of the completed checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 2/1/25. Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 1/17/25*

*On 12/18/24 RN staff nurse conducted audit to confirm submission support plans are present for all residents.*
*Within 30 calendar days of receipt of this plan of correction the administrator or designee shall develop and ensure the support plans(for admissions to SDU) for accuracy for admissions needed for the SDU.*
*Within 30 days of receipt of this report all staff responsible for completion of the support plans shall be reeducated on 2600.234a (support plans) to ensure documentation is completed in a timely manner.*
*Administrator or designee will review all documentation at the next quarterly QA meeting on January 22, 2025 and the audit documentation will be kept with the meeting notes. QA review will include all items specified in 2600.234.*
*Completion date: January 29, 2025.*

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/16/2025*

***Implemented ([redacted]) - 03/21/2025)***

## 236 - Staff Training

**30. 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**

*Direct care staff person B, who was hired on [redacted] regularly works in the home's SDCU; however, only received approximately 2.75 hours of training related to dementia care and services during the 2023 training year.*

**Plan of Correction** ***Directed ([redacted]) - 01/17/2025)***

*Staff person B will complete the required dementia training by January 29th, 2025. (DIRECTED: Documentation of direct care staff person B's training shall be kept in accordance with 2600.65i. [redacted] 1/17/25). HR will ensure all staff completes the required dementia care annual training 6hs. HR will conduct random audits monthly and indefinitely to meet this regulation.*
*Overall Completion date will be monthly and indefinitely.*
*Results will be presented and reviewed during quarterly QA meeting on January 22, 2025 for 2600.26b. Audits will be kept with the QA meeting notes. Documentation will be kept with the QA notes. QA review will include all*

## 236 - Staff Training (continued)

*items specified in 2600.236.*

*DIRECTED: Beginning on 2/1/25: Human Resources/designee shall review all training documents and the home's staff training plan on a monthly basis to ensure each direct care staff person working in the home's SDCU receives at least 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in 2600.65e during each training year. The monthly reviews shall also ensure documentation of all staff education is kept in accordance with 2600.65i. ██ 1/17/25.*

*Proposed Overall Completion Date: 01/14/2025*

**Directed Completion Date:** *02/01/2025*

***Implemented (██ - 03/21/2025)***