pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LAKEWOOD SENIOR LIVING-DRUMS LLC**
LEGAL ENTITY

To operate **FRITZINGERTOWN SENIOR LIVING COMMUNITY**
NAME OF FACILITY OR AGENCY

Located at **159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA 18222**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **164**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 60**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 2,** **2025** until **November 2,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **201661**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 2, 2025

[redacted]
Lakewood Senior Living-Drums LLC
159 South Old Turnpike Road,
Drums, PA 18222

RE: Fritzingertown Senior Living Community
License: 20166

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 20, 2025, March 6, 2025, and March 27, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 20166) dated December 19, 2024, to December 19, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated December 19, 2024, to December 19, 2025, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 2, 2025 to November 2, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *FRITZINGERTOWN SENIOR LIVING COMMUNITY* **License #:** *20166* **License Expiration:** *12/19/2025*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA 18222*

County: *LUZERNE* **Region:** *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *LAKEWOOD SENIOR LIVING-DRUMS LLC*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA, 18222*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/22/2006* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *138* **Waking Staff:** *104*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *03/27/2025*

Inspection Dates and Department Representative

03/27/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served:** *86*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Evergreen* **Capacity:** *60* **Residents Served:** *52*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *86*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *52*

Have Physical Disability: *0*

Inspections / Reviews

03/27/2025 - Partial

Lead Inspecto [redacted]

Inspections / Reviews *(continued)*

04/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/14/2025*

04/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/07/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

04/21/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *04/21/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

121a - Unobstructed Egress

1. 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

At approximately 10:30 a.m., the exit door labeled 1b in the memory care unit did not open immediately after the code was entered; the code did not appear to be working to disengage the lock. The panic bar appeared rusted and was not able to be forced open either.

The exit door located to the left of the secure dementia unit dining area was obstructed by a square dining table and two chairs that were placed in front of and up against the door. There was also a large armchair was in the foyer area leading to this exit door which also blocked the pathway to the door.

Plan of Correction ***Directed ([redacted] - 04/21/2025)***

In response to the violation on 03/27/2025 by the Pennsylvania Bureau of Human Services Licensing, immediate action was taken to enhance the currently compliant operations by removing the dining table and chairs from exit area in dining room and removal of chair near foyer entrance.
The dining chairs had been moved initially due to dining staff sweeping and washing dining room floor. Chair in foyer had been placed there while maintenance worker had been painting.

Dietary staff and maintenance staff were re-inserviced in the requirements of this regulation on 03/27/2025 and 03/28/2025
Dietary Supervisor as well as Maintenace Supervisor will monitor daily x 30 days and then weekly x 4 to ensure compliance to this regulation.
Any deficiencies will be corrected immediately and finding s will be documented and reviewed internally for continuous improvement purposes.
Exit door at 1B required service by our contracted alarm company. Door was repaired on 04/04/2025 .See attached documentation of repair.
Documentation of re-inservicing is attached.

Exit door at 1B required service by our contracted alarm company. Door was repaired on 04/04/2025. See attached documentation of repair. Door easily opens when code entered. Also confirmed that door opens when fire alarms triggered.

Proposed Overall Completion Date: 05/27/2025

Directed: In addition to the plan, the audits being completed by the Dietary and Maintenance Supervisor will de done on all exit doors daily for 30 days and then weekly for 8 weeks. Documentation of these audits will be kept including date of checks, person completing checks, and issues or concerns identified by the checks.

Directed Completion Date: *05/13/2025*

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident #1 has an order for Metoprolol 25mg, one tablet daily, hold for systolic blood pressure less than 100 or heart rate less than 55. On 3/19/25 at 8:30 a.m., resident #1's systolic blood pressure was 98 and the medication was administered.

Plan of Correction ***Directed ([redacted] 04/16/2025)***

In response to the violation on 03/27/2025 by the Pennsylvania Bureau of Human Services Licensing the Director of Nursing re-inserviced all LPN's and Med techs in the requirement of this regulation and that care must be taken to follow all prescriber's order, in this case the parameters of the MD, and properly document all medications as they are administered with accuracy to be incompliance with this regulation. This re-inservicing occurred on 03/27/2025 and 03/28/2025.

Effective 03/28/2025 the Executive Director will perform monthly audits x3 through 06/28/2025 to maintain ongoing compliance.

Any deficiencies will be corrected immediately and finding s will be documented and reviewed internally for continuous improvement purposes.

Documentation of re-inservicing is attached.

Proposed Overall Completion Date: 06/28/2025

Directed: In addition to the above plan, the administrator or designee will conduct 1 observation of a medication pass weekly for 4 weeks to verify that all medication pass actions are being completed correctly. Any errors will be documented and remedial training given to responsible staff member prior to passing medications again. These observations will be documented with date, time, staff member passing medications, staff member observing, and any issues identified.

Directed Completion Date: *05/13/2025*

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

Facility Information

Name: *FRITZINGERTOWN SENIOR LIVING COMMUNITY* **License #**: *20166* **License Expiration**: *12/19/2025*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA 18222*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name [redacted]

Legal Entity

Name: *LAKEWOOD SENIOR LIVING-DRUMS LLC*

Addres [redacted]

Phone:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/22/2006* **Issued By**: *PA Dept. L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *88* **Waking Staff**: *66*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/24/2025*

Inspection Dates and Department Representative

03/06/2025 - On-Site: [redacted]
03/10/2025 - Off-Site:
03/17/2025 - Off-Site:
03/18/2025 - Off-Site:
03/20/2025 - On-Site:
03/21/2025 - Off-Site:
03/24/2025 - Off-Site:

Resident Demograph pection Dates

General Information

License Capacity: *164* **Residents Served**: *85*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Evergreen* **Capacity**: *60* **Residents Served**: *25*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *84*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *3* **Have Physical Disability**: *1*

Inspections / Reviews

03/06/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/18/2025*

04/21/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

04/21/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *04/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

42b - Abuse

1. Requirements

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

Description of Violation

On 3/4/25 at approximately 1:15 a.m., Staff Persons A and B were providing care to Resident #1 who became combative because Staff Person A would not allow them to brush their teeth. When Staff person C entered the room to assist, they observed Resident #1 kicking Staff Person A. Staff person C then heard Staff Person A say to Resident #1, "if you keep kicking me, I'll break your f---ing legs". Staff Person B then attempted to assist Resident #1 out of bed and take them to the bathroom to brush their teeth. Staff Person C witnessed Staff Person A stop them, pick up Resident #1 under the arms and "throw" the resident onto the bed. Staff Person B then heard Resident #1 say, "you hurt me".

Staff Person D reported that recently, during the second shift, Staff Person A showed them a video on their cell phone which recorded how Staff Person A placed Resident #1 in a Hoyer Lift, at the highest level, to "control their behaviors". Resident #1 was observed in the video, "dangling from the sling" and unable to move, while Staff Person E was laughing. When Staff Person D asked Staff Person A why they did that to Resident #1, Staff Person A responded that Resident #1 spit on them, so they wiped the spit off and shoved it back into the Resident #1's mouth. In the same video, Staff Person D viewed Resident #1 throwing a pillow at Staff Person E and Staff Person E throwing the pillow back at Resident #1, while both Staff Persons A and E were laughing.

Repeat Violation: 12/4/24

Plan of Correction ***Directed [redacted] 04/21/2025)***

In response to the violation reported on 03/04/2025, an investigation was immediately initiated by the Executive [redacted] Witnesses (Employee C and D) were interviewed, Based on investigation and interviews Employees A and E were [redacted] from employment at our facility.

On 03/04/2025 an incident report was issued to the Bureau of Human Services Licensing as well as the Area Agency on Aging.
A report was also sent to the Butler Township Police Department, The officer stated that a report was initiated but charges would not be filed at that time.

On 03/06/2025,03/07/2025 and 03/10/2025 employees received re-inservicing regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Right to Privacy of Self and Possessions, Restraints as well as all components of regulation 2600 .42b.
Each employee verbalized understanding of these elements. This retraining was done by Linda Palermo RN, Director of Nursing.

Additionally, revisions were made to mandated abuse portion of the employee's handbook to ensure clarity and compliance.

Beginning 03/11/2025 Director of Nursing will perform quarterly re-inservices regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Restraints and the components of this regulation.

42b - Abuse (continued)

Executive Director will monitor daily for compliance to this regulation and immediately report any violation.

Any deficiencies regarding this regulation will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

See attached retraining documents.
Also attached are the formal termination letters for Employee A and Employee E.
See attached updates to facility employee handbook

Proposed Overall Completion Date: 04/09/2025

(Directed)
In addition to the above noted plan: All staff will be trained in Resident Rights and The Older Adults Protective Services Act by an outside source including the Administrator. The Administrator will observe interactions with staff members and residents in the homes Secured Dementia Care Unit on 3rd shift one day per week for 3 months. These observations will be on different days of the week, when different staff are working and different times of the shift. These observations will be documented and any problems will be addressed immediately.

Directed Completion Date: *05/13/2025*

42s - Privacy

2. Requirements

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

Description of Violation

Staff Person D reported that recently, during the second shift, Staff Person A showed them a video on their cell phone which recorded how Staff Person A placed Resident #1 in a Hoyer Lift, at the highest level, to "control their behaviors". Resident #1 was observed in the video, "dangling from the sling" and unable to move. In the same video, Staff Person D viewed Resident #1 throwing a pillow at Staff Person E and Staff Person E throwing the pillow back at Resident #1, while both Staff Persons A and E were laughing. Staff may not photograph or video record residents with private cell phones or other electronic devices.

Plan of Correction ***Directed [redacted] 04/21/2025)***

In response to the violation reported on 03/04/2025, an investigation was immediately initiated by the Executive [redacted] Witnesses (Employee C and D) were interviewed, e [redacted] from employment at our facility.

On 03/04/2025 an incident report was issued to the Bureau of Human Services Licensing as well as the Area Agency on Aging.
A report was also sent to the Butler Township Police Department, The officer stated that a report was initiated but charges would not be filed at that time.

42s - Privacy (continued)

On 03/06/2025,03/07/2025 and 03/10/2025 employees received re-inservicing regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Right to Privacy of Self and Possessions, Restraints as well as all components of regulation 2600 .42b.
Each employee verbalized understanding of these elements. This retraining was done by [redacted] *of Nursing.*

Additionally, revisions were made to mandated abuse portion of the employee's handbook to ensure clarity and compliance.

Beginning 03/11/2025 Director of Nursing will perform quarterly re-inservices regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Restraints and the components of this regulation.

Executive Director will monitor daily for compliance to this regulation and immediately report any violation.

Any deficiencies regarding this regulation will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

See attached retraining documents.
Also attached are the formal termination letters for Employee A and Employee E.
See attached updates to facility employee handbook

Proposed Overall Completion Date: 04/08/2025

(Directed)
In addition to the above noted plan: The home will train all staff in the homes internal policy regarding cell phone use. Staff may not photograph or video record residents with private cell phones or other electronic devices. If the home does not have a policy, the home will immediately create one and enforce it with the staff. The Administrator will conduct weekly observations of staff following the policy immediately for 3 months. These observations will be on different days of the week, different shifts, and when different staff are working. These observations will be documented and any problems will be addressed immediately.

Directed Completion Date: *05/13/2025*

202 - Prohibitions

3. Requirements

2600.
202. The following procedures are prohibited:

202 - Prohibitions *(continued)*

5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

Description of Violation

Staff Person D reported that recently, during the second shift, Staff Person A showed them a video on their cell phone which recorded how Staff Person A placed Resident #1 in a Hoyer Lift, at the highest level, to "control their behaviors". Resident #1 was observed in the video, "dangling from the sling" and unable to move. Resident #1 was mechanically restrained by Staff person A.

Plan of Correction ***Directed [redacted] 04/21/2025)***

In response to the violation reported on 03/04/2025, an investigation was immediately initiated by the Executive [redacted] Witnesses (Employee C and D) were interviewed, Based on investigation and interviews Employees A and E were [redacted] from employment at our facility.

On 03/04/2025 an incident report was issued to the Bureau of Human Services Licensing as well as the Area Agency on Aging.
A report was also sent to the [redacted] Police Department, The officer stated that a report was initiated but charges would not be filed at that time.

On 03/06/2025,03/07/2025 and 03/10/2025 employees received re-inservicing regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Right to Privacy of Self and Possessions, Restraints as well as all components of regulation 2600 .42b.
Each employee verbalized understanding of these elements. This retraining was done by [redacted] Director of Nursing.

Additionally, revisions were made to mandated abuse portion of the employee's handbook to ensure clarity and compliance.

Beginning 03/11/2025 Director of Nursing will perform quarterly re-inservices regarding Abuse, Mandatory Reporting of Abuse Residents Rights, Restraints and the components of this regulation.

Executive Director will monitor daily for compliance to this regulation and immediately report any violation.

Any deficiencies regarding this regulation will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

See attached retraining documents.
Also attached are the formal termination letters for Employee A and Employee E.
See attached updates to facility employee handbook

Proposed Overall Completion Date: 04/09/2025

202 - Prohibitions (continued)

(***Directed)***
In addition to the above noted plan: All staff will have training in positive interventions. The Administrator will conduct weekly observations of staff and residents immediately for 3 months. These observations will be on different days of the week, different shifts, and when different staff are working. These observations will be documented and any problems will be addressed immediately.

Directed Completion Date: *05/13/2025*

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

Facility Information

Name: *FRITZINGERTOWN SENIOR LIVING COMMUNITY* **License #**: *20166* **License Expiration**: *12/19/2025*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA 18222*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

Name [redacted]

Legal Entity

Name: *LAKEWOOD SENIOR LIVING-DRUMS LLC*

Address: *159 SOUTH OLD TURNPIKE ROAD, DRUMS, PA, 18222*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/22/2006* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *126* **Waking Staff**: *95*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/20/2025*

Inspection Dates and Department Representative

02/20/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served**: *97*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Evergreen* **Capacity**: *60* **Residents Served**: *24*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *96*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

02/20/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/07/2025*

Inspections / Reviews *(continued)*

03/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/13/2025*

03/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/18/2025*

04/23/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act requires that carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. The home has a propane gas-fired furnace in the basement; however, no carbon monoxide detector was present in close proximity to the stove.

Plan of Correction ***Accept [redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *On 02/22/2025 a carbon monoxide detector was installed in furnace room by the Maintenance Director as required.*

(Photo is attached)

To enhance the currently compliant operations, Maintenance Director will monitor monthly to ensure carbon monoxide detector is functioning properly.

Effective 02/25 2025 the Executive Director will perform monitoring audits to maintain ongoing compliance with applicable Federal, State and local laws, ordinances and regulations. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented [redacted] 03/14/2025)

65g - Annual Training Content

3. 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:

Description of Violation

Staff person B (DOH [redacted]15), Staff person C (DOH [redacted]9), Staff person D (DOH [redacted]18), and Staff person E (DOH [redacted]3) did not receive the required fire safety training from a fire safety expert for the 2024 training year.

Plan of Correction ***Accept [redacted] 03/11/2025)***

Although staff persons B, C, D, and E each received 2024 annual fire safety training via a permitted video program prepared by a certified fire safety expert, it was alleged during the survey that requirement was not met because the person present when the training video was presented to these staff members was unable to produce evidence that

65g - Annual Training Content (continued)

[redacted]*was trained by a certified fire training expert. Facility will ensure that in the future the person presenting the approved fire safety video has received the requisite training from a fire safety expert to enable that person to answer any questions posed by those staff members receiving training, and evidence of this training will be available upon request.*

Employee from Maintenance Department - [redacted] *is registered for Fire Safety Training on 03/12/2025 -See attached proof of registration*

Proposed completion date is 4/1/2025

Licensee's Proposed Overall Completion Date: *04/01/2025*

Implemented [redacted] ***- 03/14/2025)***

82a - Poisonous Materials

4. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

A bottle filled with blue liquid was found in the main laundry room with a manufacturer's label identifying it as Spin and Span cleaner and a piece of masking tape on it with the word Windex written on the tape. Staff confirmed the liquid in the bottle was Windex and not Spin and Span cleaner.

Plan of Correction ***Accept (*** [redacted] ***- 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Housekeeping by removing and disposing of the bottle immediately.

To enhance the currently compliant operations, on 02/22/2025 the Housekeeping Director will retrain housekeeping staff in the requirements of this regulation (In-service sheets attached),

Effective 03/05/2025 the Executive Director will perform monthly audits through 10 05/2025 to maintain ongoing compliance with storing poisonous materials in their original, labeled containers. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented ([redacted] ***- 03/14/2025)***

82c - Locking Poisonous Materials

5. Requirements

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

Description of Violation

At approximetly 9:30 a.m. in the home's secure dementia unit the following was found in the unit accessible to residents who are unsafe to use and/or avoid poisonous materials:

82c - Locking Poisonous Materials (continued)

Toothpaste was found in the bathroom of resident #3. The label on the tube of toothpaste indicated if ingested in a large amount get medical help or contact poison control. Resident #3 is assessed as unsafe around poisonous materials. Repeat Violation: 2/21/24

Plan of Correction ***Accept ([redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Secured Dementia Unit, Kristyna Kiefer to remove the addressed items and place them in locked area.

To enhance the currently compliant operations, the Director of Nursing provided re-inservicing to personal care and licensed staff in the requirements of this regulation and need for ongoing compliance for resident safety. (Training sign-in sheets attached)

Effective 03/05/2025 the Director of Nursing will perform monthly audits through 10/05/2025 to maintain ongoing compliance with this regulation.

Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented [redacted] 03/14/2025)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident # 1's glucometer was used to test the blood sugar of Resident #2 on 2/17/25 at 7:42 a.m.

Plan of Correction ***Accept ([redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of our Secured Dementia unit.
Contaminated glucometer was disposed of .
Glucometers were distinctly identified to prevent future misidentification in the future.

To enhance the currently compliant operations, on 02/21/2025, LPN's and med techs were reinserviced by the Director of Nursing in the requirements of this regulation with a completion date of 02/23/2025.

Effective 03/23/2025 the Director of Nursing will perform monthly audits of all glucometers for distinct identification and reviewed internally for continuous improvement purposes.

Inservice training sheets are attached.

85a - Sanitary Conditions *(continued)*

Licensee's Proposed Overall Completion Date: *03/03/2025*

Implemented [redacted] 03/28/2025)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximetly 9:45 a.m., the trash can located in the Secured Dementia Care kitchen did not have a lid covering the trash and there were no staff in the kitchen actively using the trash can.

Plan of Correction ***Accept [redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Dietary Services [redacted], by placing a lidded trash can in the SDU kitchen.

To enhance the currently compliant operations, on 02/21/2025, Dietary staff were reinserviced by the Director of Dietary Services in the requirements of this regulation with a completion date of 02/23/2025.

Effective 03/23/2025 the Director of Dietary Services will perform monthly audits of all trash cans to ensure all lids remain intact and reviewed internally for continuous improvement purposes.

Photo of lidded trash can in SDU is attached .
Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/03/2025*

Implemented [redacted] 03/28/2025)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents in rooms 16 and 20 did not have an operable lamp or other source of lighting that could be turned on at bedside. Repeat Violation: 2/21/2024

Plan of Correction ***Accept [redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Housekeeping, [redacted] to place a touch lamp device on the bedside table of the residents in these rooms.

101j7 - Lighting/Operable Lamp (continued)

To enhance the currently compliant operations, on 02/21/2025 the Housekeeping Director reinserviced housekeeping staff in the requirements of this regulation with a completion date of 02/22/2025.

Effective 02/23/2025 the Housekeeping Director will perform monthly audits x4 months through 06/23/2025 to maintain ongoing compliance and will monitor each room ensuring each resident has in their bedroom an operable lamp or other source of lighting that can be turned on at bedside.
Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented [redacted] - 03/28/2025)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

During the physical site inspection at 1:45 p.m, there was no thermometer found in the Secured Dementia Kitchen freezer.

Plan of Correction ***Accept ([redacted] - 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Dietary Services by placing a thermometer in the freezer section of refrigerator in the kitchen of SDU.

(Photo is attached)

To enhance the currently compliant operations, on 02/21/2025 the Director of Dietary Services reinsserviced dietary staff in the requirements of this regulation, with a completion date of 02/23/2025.

Effective 02/23/2025 the Director of Dietary Services will perform monthly x4 through 06/23/2025 to maintain ongoing compliance with this regulation and will monitor each refrigerator of the facility ensuring food requiring refrigeration is stored at or below 40°F, and frozen food is kept at or below 0°F, and thermometers are present in refrigerators and freezers.
Any deficiencies will be corrected immediately, and findings will be documented and reported to the Executive Director for further review and continuous improvement.
Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *06/23/2025*

121a - Unobstructed Egress

10. Requirements

121a - Unobstructed Egress *(continued)*

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

Description of Violation

At approximetly 9:35 a.m. the exit door labeled 1b in the memory care unit did not open immediately after the code was entered into the keypad to unlock the door. The door was equipped with a panic bar that was rusted and sticking and therefore required excessive force to push the door open.

Plan of Correction ***Accept ([redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Maintenance Director to make repairs to the door and panic hardware to allow ease of opening.

To enhance the currently compliant operations, on 02/21/2025 the Maintenance Director reinserviced all secured dementia unit staff including, personal care staff and all ancillary staff in the requirements of this regulation. Staff made aware to immediately report any exit or internal doors that do not open with ease and do not "stick "(with a completion date of 02/24/2025).

Effective 03/24 /25 the Executive Director will perform monthly audits x4 of exit doors throughout the facility to ensure proper maintenance and to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Staff training documentation attached .

Licensee's Proposed Overall Completion Date: *07/24/2025*

131e - Accessible Extinguishers

11. Requirements

2600.
131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

The fire extinguishers located behind locked glass containers in the memory care unit were not equipped with keys to open and access the fire extinguishers. Staff indicated they were not provided with keys to the fire extinguisher cases and could not immediately identify the correct key to open the cases.

Plan of Correction ***Accept [redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Maintenance Director to tape the appropriate key to the underside of the casing of the fire extinguishers.

To enhance the currently compliant operations:

1. On 02/21/2025 the Executive Director reinserviced all staff in the requirements of this regulation.

131e - Accessible Extinguishers (continued)

2. *Magnetic boxes with keys were placed under the casing of each fire extinguisher in the SDU, with a completion date of 02/25/2025.*
3. *On 02/23/2025 the Maintenance Director trained all staff of the memory care unit in the placement and presence of the magnetic boxes and the action of obtaining key for fire extinguisher in the event of emergency.*
4. *Maintenance Director will monitor monthly x4 for the presence of the magnetic boxes as well as the key, with a completion date of 06/23/2025.*

The overall completion date is 06/23/2025.

Effective 03/23/2025 the Executive Director will perform monthly x3 monitoring audits of fire extinguisher cases for magnetic box and key through 06/23/2025 to maintain ongoing compliance with this regulation and ensuring fire extinguishers are accessible to staff persons, and to keep fire extinguishers locked if access to the extinguisher by a resident could cause a safety risk to the resident, and if fire extinguishers are kept locked, to ensure each staff person is able to immediately unlock the fire extinguisher in the event of a fire emergency. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *06/23/2025*

132g - Fire Drills Days/Times

12. 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 conducted a sleeping hour fire drill in the personal care area on 5/31/24 with 7 staff present at 11:30 p.m. The next sleeping hour fire drills in personal care were conducted on 8/23/24 at 6:00 a.m. with 12 staff and on 11/19/24 at 6:15 a.m. with 16 staff. The home regularly schedules a total of 6 to 7 direct care staff persons during 3rd shift hours of 11:00 p.m. to 7:00 a.m. The home's last two sleeping hour fire drills conducted in the personal care unit were conducted at times when additional staff were available to assist in the fire drills.

Plan of Correction ***Accept [redacted] 03/11/2025)***

On 02/21/2025 the Executive Director reinserviced all Maintenance staff in the requirements of this regulation.

on 02/23/2025 the Maintenance Director trained all overnight staff in the requirements of this regulation as well as their responsibilities in a safe evacuation of all residents in an overnight fire drill.

132g - Fire Drills Days/Times (continued)

To enhance the current compliant operations the Maintenance Director will perform fire drills and monitor fire drill logs monthly x 6 for the presence of an overnight fire drill at times when additional staff are not present.

Effective 03/23/2025 the Executive Director will perform monthly x 6 monitoring audits of fire drill logs to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Overnight fire drill is scheduled between the hours of 1 am and 5 am on
Monday 03/10/2025.
Inservicing documents are attached.
Fire drill log attached .

Licensee's Proposed Overall Completion Date: *03/10/2025*

Not Implemented [redacted] 04/17/2025)

141a 1-10 Medical Evaluation Information

13. Requirements

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

Description of Violation

Resident #4's initial Medical Evaluation was completed on [redacted]/24. The Medical Evaluation did not include the physicians name or medical license number. Resident #5's initial Medical Evaluation was completed on [redacted]/24. The Medical Evaluation did not include the physician's name.

Plan of Correction ***Accept ([redacted] 03/11/2025)***

On 02/21/2025 the Executive Director reinserviced Director of Nursing and nursing staff in the requirements of this regulation as well as their responsibilities in ensuring that all aspects of the DME form are complete and legible following physician completion of form .

To enhance the current compliant operations the Director of Nursing will perform monthly audits x3 for the presence of all required aspects of the DME including physician signature, license number, printing of physician name and date of completion.

141a 1-10 Medical Evaluation Information (continued)

Effective 03/23/2025 the Executive Director will perform monthly x 3 monitoring audits to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes, with a completion date of 06/23/2025.

Inservicing documents are attached.
DME for Resident #4 was corrected on 02/25/2025 and DME for Resident #5 was corrected on 02/28/2025

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented ([redacted] 03/28/2025)

144c1 - Smoking Area Guidelines

14. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

At about 10:00 a.m there were approximately 12 cigarette butts were observed on the ground mixed with dried leaves in the home's outdoor smoking area.

Plan of Correction ***Accept [redacted] 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken 02/20/2025 by the Housekeeping Director who immediately removed all cigarette butts laying on ground.

On 02/20/2025 the Executive Director spoke to only smoking resident to stress compliance with smoking regulations of facility and the danger of not using appropriate extinguishing materials provided.

To enhance the currently compliant operations, on 02/22/2025 the Director of Housekeeping reinserviced all housekeeping and maintenance staff in the requirements of this regulation as well as their responsibilities in ensuring compliance with all fire safety procedures including the appropriate extinguishing and disposal of all smoking debris

To enhance the current compliant operations the Director of Maintenance Richard Lech will perform monthly audits x3 for the presence of and proper disposal of any cigarette butts on the property.

Effective 03/23/2025 the Executive Director will perform monthly x 3 monitoring audits to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes, with a completion date of 06/23/2025.

Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/23/2025*

Implemented [redacted] - 03/28/2025)

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 #6 has an order for Tylenol 325mg, 2 tablets every four hours as needed. The home did not have this medication on hand to administer if needed.

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff recording the blood glucose test results inaccurately on the MAR:
Resident #2: At 4:30pm on 2/19/25, the glucometer reading was 275 but the reading documented on the MAR was 289.
Repeat Violation: 2/21/24

Plan of Correction ***Accept ([redacted] - 03/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 02/20/2025 by the Director of Nursing who called responsible party to obtain prescribed OTC medication from RP who is responsible for obtaining all OTC medications.
Additionally, care must be taken to properly document all glucometer readings with accuracy as required to be in compliance with this regulation.
To enhance the currently compliant operations, on 02/21/2025 the Director of Nursing reinserviced all LPN's and Med techs in the requirement of this regulation. Families obtaining medication or OTC must be given ample time to ensure prompt delivery of medications, with a completion date of 02/24/2025.

Effective 03/23/2025 the Executive Director will perform monthly audits through 06/23/2025 to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.
Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Implemented [redacted] 03/28/2025)

187b - Date/Time of Medication Admin.

17. 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 #7 has an order for Levothyroxine 25mcg, 1 tablet in the morning. On 2/8/25 the medication was administered as ordered but staff who administered the medication did not initial the MAR.

Plan of Correction ***Accept [redacted] 03/06/2025)***

To enhance the currently compliant operations, on 02/22/2025 Director of Nursing re-inserviced all LPN's and Med techs in the requirement of this regulation and that care must be taken to document all medications as they are administered with accuracy to be in compliance with this regulation.

Effective 03/23/2025 the Executive Director will perform monthly audits x3, through 06/23/2025, to maintain

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

ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented ([redacted] 03/28/2025)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident #8 has an order for Metoprolol 25mg, 1 tablet daily, hold for heart rate under 60 or blood pressure under 110. On the following dates and times the resident's heart rate was not measured prior to administration of the medication: 2/8/25 at 7:55 a.m; 2/9/25 at 7:50 a.m; 2/10/25 at 7:30 a.m.

Plan of Correction ***Accept [redacted] 03/06/2025)***

To enhance the currently compliant operations, on 02/22/2025 Director of Nursing re-inserviced all LPN's and Med techs in the requirement of this regulation and that care must be taken to follow all prescriber's order, in this case, the parameters ordered by the MD, and properly document all medications as they are administered with accuracy to be in compliance with this regulation.

Effective 03/23/2025 the Executive Director will perform monthly audits x3 ,through 06/23/2025, to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/04/2025*

Not Implemented [redacted] 04/03/2025)

231b - Medical Evaluation

20. 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 #11 was admitted to the Secure Dementia Care Unit on [redacted]24. The resident's Medical Evaluation was completed on 12/4/24.

Plan of Correction ***Accept [redacted] 03/06/2025)***

On 02/21/2025 the Executive Director reinserviced Director of Nursing and nursing staff on this mistaken error in dating required forms

231b - Medical Evaluation (continued)

and the requirements of this regulation as well as their responsibilities in ensuring that all aspects of the Resident Assessment and Support Plans form are complete and accurate.

To enhance the current compliant operations the Director of Nursing will perform monthly audits x3 for the presence of all required aspects of the Resident Assessment and Support Plans forms and that they are complete and accurate.

Effective 03/23/2025 the Executive Director will perform monthly x 3 monitoring audits to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes, with a completion date of 06/23/2025.
Inservicing documents are attached.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented [redacted] 03/28/2025)

233c - Key-Locking Devices

21. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

At approximetly 9:40 a.m. in the home's secure dementia unit there was no code posted at or near the key pad for the exit door located next to the laundry area. In addition, there was no code posted at or near the key pad for the exit door located in the secure dementia dining area.

Plan of Correction ***Accept [redacted] 3/06/2025)***

In response to the violation on 02/20/2025 by the Pennsylvania Bureau of Human Service Licensin ediate action was taken on 02/20/2025 by the Maintenance Director to Code plaques were replaced in areas addressed.

To enhance the currently compliant operations, on 02/21/2025 the Maintenance Director will reinserviced all secured dementia unit staff including, personal care staff and all ancillary staff in the requirements of this regulation. Staff made aware that code posting must be available and legible at all times and should immediately report any code posting which is not available and legible, with a completion date of 02/24/2025.

Effective 03/24 /25 the Executive Director will perform monthly audits of code postings through 07/24/2025 to maintain ongoing compliance with this regulation. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *07/24/2025*