

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

June 27, 2025

[REDACTED]  
LANCASTER PCH LLC  
[REDACTED]

RE: LEGEND PERSONAL CARE AND  
MEMORY CARE OF LANCASTER  
31 MILLERSVILLE ROAD  
LANCASTER, PA, 17603  
LICENSE/COC#: 33306

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/16/2025, 04/17/2025 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:** LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER      **License #:** 33306      **License Expiration:** 07/09/2025

**Address:** 31 MILLERSVILLE ROAD, LANCASTER, PA 17603

**County:** LANCASTER      **Region:** CENTRAL

**Administrator**

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

**Legal Entity**

**Name:** LANCASTER PCH LLC

**Address:** [REDACTED]

**Phone:** [REDACTED]      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** I-1      **Date:** 12/11/2004      **Issued By:** Manor Township

**Type:** I-2      **Date:** 12/11/2004      **Issued By:** Manor Township

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 112      **Waking Staff:** 84

**Inspection Information**

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

**Reason:** Complaint, Incident      **Exit Conference Date:** 04/17/2025

**Inspection Dates and Department Representative**

04/16/2025 - On-Site: [REDACTED]

04/17/2025 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 100      **Residents Served:** 79

**Secured Dementia Care Unit**

**In Home:** Yes      **Area:** Memory Care      **Capacity:** 33      **Residents Served:** 30

**Hospice**

**Current Residents:** 8

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0      **Are 60 Years of Age or Older:** 79

**Diagnosed with Mental Illness:** 0      **Diagnosed with Intellectual Disability:** 1

**Have Mobility Need:** 33      **Have Physical Disability:** 0

**Inspections / Reviews**

04/16/2025 Partial

**Lead Inspector:** [REDACTED]      **Follow-Up Type:** POC Submission      **Follow-Up Date:** 05/19/2025

Inspections / Reviews (*continued*)

## 05/21/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/15/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 05/28/2025

## 05/23/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/15/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/16/2025

## 06/27/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/15/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

## 16c - Written Incident Report

## 1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

## Description of Violation

On [REDACTED], at approximately 5:47 PM, staff member A and staff member B were in the hallway walking resident [REDACTED] room. Staff members A and B heard a slap sound and then heard resident [REDACTED] sounding like [REDACTED] was crying. Staff members A and B overheard staff member C state, "I did not hit you that hard." The home did not report this incident to the Department until [REDACTED] at 1:07 PM.

On [REDACTED], resident [REDACTED] eloped from the home's Secured Dementia Care Unit and was found by police at approximately 9:00 PM. The resident was found approximately 5.5 miles away from the home, walking along Route 30 near Prospect Road in Columbia. However, this was not reported to the Department until [REDACTED] at 3:15 PM.

Repeated Violation - [REDACTED], et al and [REDACTED], et al

## Plan of Correction

Accept [REDACTED] - 05/23/2025)

- Unable to correct; written incident report for incident on 4/2/25 and incident on 4/6/25 were reported late to the department.
- On 4/6/2025 RDO provided education to Administrator on reportable incidents and provided the correct email to send incidents and regulation 2600.16c. Documentation shall be kept.
- By 5/1/2025, the administrator shall review previous 30 days of incidents to ensure required written incident reports have been submitted to the correct governing agency.
- Beginning 5/1/2025, the administrator or healthcare director shall review incidents as needed to ensure timely reporting; this review will occur daily and continue for 4 weeks.
- To ensure consistent adherence to Regulation 2600.16c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [REDACTED] - 06/17/2025)

## 42b - Abuse

## 2. 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

Resident [REDACTED] was initially admitted to the home under personal care on [REDACTED] but was moved to the home's Secure Dementia Care Unit (SDCU) after the resident attempted to leave the home three times on [REDACTED]. Following the resident's move to the SDCU, the resident had been observed multiple times by staff trying to leave the SDCU through the dining room door that led to the outside of the building. On [REDACTED] at approximately 9:00 PM, resident [REDACTED] was

**42b Abuse (continued)**

found by police walking along ██████ near ██████, which is approximately 5.5 miles away from the home. The home was unaware the resident had been missing until police contacted the home, at approximately 10:30 PM, stating the resident had been found. Staff member D, who was on shift the evening of ██████, stated ██████ did not include the resident in ██████ 9:00 PM to 9:30 PM rounds. Staff member E, who received the call from police that evening, reported there was no way the aides working that evening included the resident in their 8:00 PM to 8:30 PM rounds. On ██████, agents of the Department inspected the door in the SDCU that the resident has used in attempting to leave the home. The agents of the Department observed this door did not completely latch close.

On ██████ at approximately 9:05 PM, in the SDCU, staff discovered resident ██████ in the apartment of resident ██████. Both residents were undressed, and resident ██████ was performing a sexual act on resident ██████. The residents were separated. Resident ██████ was taken back to ██████ room. Both residents' have a diagnosis of ██████ and have a need to reside in SDCU. There is no indication in either resident ██████ or resident ██████ records indicating their ability to consent to sexual contact, and the home has not had either resident evaluated by a medical professional to determine the residents' ability to consent.

Repeated Violation ██████, et al

**Plan of Correction**

Accept ██████ 05/23/2025)

Resident ██████ was assessed by the med tech on duty on ██████, no injuries noted, support plan updated with incident and interventions. Staff on duty performed head count and all residents were present and accounted for.

On 4/13/2025 Resident ██████ and resident ██████ were assessed by med tech on duty, no injuries noted. Both responsible parties and physicians notified. Resident ██████ and resident ██████ support plans updated to reflect the incident and interventions.

On 4/21/2025, the administrator conducted an elopement drill.

By 4/10/2025 the administrator shall educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.

On 4/21/2025, the maintenance director checked the outside exit door to ensure proper operation and tightened the latch.

By 5/29/2025 the administrator shall re educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.

Beginning 5/16/2025 the administrator shall interview 5 residents weekly X 4 weeks to ensure safety and needs are being met.

To ensure consistent adherence to Regulation 2600.42b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented ██████ - 06/17/2025)

**82c - Locking Poisonous Materials****3. Requirements**

2600.

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

82c - Locking Poisonous Materials (continued)

**Description of Violation**

On [REDACTED], at approximately 10:15 AM, a Dove Advanced Care Deodorant stick with a manufacturer's label indicating "If swallowed, get medical help or contact a Poison Control Center right away," and a bottle of Eucerin Itch Relief Intensive Calming Lotion with a warning label stating, "Keep out of reach of children, get medical help or contact a Poison Control Center right away" were unlocked, unattended, and accessible in resident [REDACTED] and resident [REDACTED] shared room. Not all the residents of the home, including Resident [REDACTED] and Resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

On [REDACTED], at approximately 10:20 AM, two containers of Clorox disinfecting wipes with a manufacturer's label stating, "call a poison control center for treatment advice" was unlocked, unattended, and accessible in resident [REDACTED] room. Not all the residents of the home, including resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

**Plan of Correction**

Accept [REDACTED] - 05/21/2025)

-On 4/17/25, day of survey, the administrator secured the Dove Advanced Care Deodorant Stick and the bottle of Eucerin Itch Relief Intensive Calming Lotion from resident [REDACTED] and resident [REDACTED] shared room. The Clorox Disinfecting Wipes were removed resident [REDACTED] room.

-On 4/18/2025, the administrator audited remaining memory care apartments for compliance with regulation 2600.82c. Any further findings corrected at time of audit.

-By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.82c, documentation shall be kept.

-Beginning 5/16/2005, the administrator or designee shall audit 5 memory care apartments daily on work days X 4 weeks to ensure compliance with regulation.

-- To ensure consistent adherence to Regulation 2600.82c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [REDACTED] - 06/17/2025)

85a - Sanitary Conditions

**4. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

**Description of Violation**

On [REDACTED], at approximately 10:57 AM, a portable urinal was hanging on the toilet grip bar in resident [REDACTED] room. The [REDACTED] had [REDACTED] caked around the rim. The toilet had feces splatter around the inside of the toilet as well as on the toilet seat. Also, the bathroom trash can had feces on the edge of the lid.

## 85a - Sanitary Conditions (continued)

**Plan of Correction****Accept** [REDACTED] - 05/21/2025)

-On 4/17/25, at time of survey, resident [REDACTED] bathroom including the urinal and trashcan were cleaned by the housekeeper.

-On 4/18/2025, the maintenance director or designee audited remaining bathrooms for cleanliness, any further findings corrected at time of audit.

-By 5/29/2025, the administrator or designee to educate current staff on regulation 2600.85a, documentation shall be kept.

-Beginning 5/16/2005, the administrator or designee shall observe 5 bathrooms weekly X 4 weeks to ensure adherence to regulation.

- To ensure consistent adherence to Regulation 2600.85a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

**Implemented** [REDACTED] - 06/17/2025)

## 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**

The door in the Secure Dementia Care Unit (SDCU) adjacent to resident room [REDACTED] has a code box. On [REDACTED], at approximately 9:55 AM, the code box was not functioning, and the push bar did not open the door, preventing immediate egress.

**Plan of Correction****Accept** [REDACTED] - 05/21/2025)

- The lock on the egress door outside of room [REDACTED] disengages when the alarm is sounding as evidenced during the monthly fire drills.

-4/18/2025, Maintenance Director contacted the alarm company to correct the code box, the alarm company is expected at the home 5/20/2025.

-On 4/18/2025 the maintenance director or designee tested remaining secure doors for proper functioning.

-By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.121a and the process for communication if keypads are not functioning, documentation shall be kept.

-Beginning 4/18/2025, the administrator or designee shall test secure memory care doors weekly X 4 weeks.

- To ensure consistent adherence to Regulation 2600.121a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

121a - Unobstructed Egress (*continued*)*Implemented* [REDACTED] - 06/17/2025)

## 144c1 - Smoking Area Guidelines

**7. 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**

The home's designated smoking area is at the delivery entrance area. On [REDACTED], at approximately 10:00 AM, numerous cigarette butts were observed outside the exit door of the Secure Dementia Care Unit located by the dumpsters.

On [REDACTED] at 1:05 PM, resident [REDACTED] was observed sitting on his/her walker smoking a pipe in the center courtyard.

**Plan of Correction***Accept* [REDACTED] 05/21/2025)

-On 4/17/2025 at the time of the incident, Administrator and a representative from DHS meet with resident 5 and provided verbal education.

-On 4/18/2025, the administrator or designee removed the cigarette butts from the area outside the exit of the SDU by the dumpsters.

- By 4/21/2025, the administrator or designee to inspect remaining outside areas for cigarette butts, further findings addressed at time of audit.

-By 5/29/2025, the administrator or designee to educate current staff on smoking area, company smoking policy and regulation 2600.144c1. Documentation shall be kept.

-On 5/6/2025, the administrator spoke with resident 5 and had resident re-sign the smoking policy.

-Beginning 4/29/2025, the administrator or designee shall observe outside areas 3 X weekly X 4 weeks for compliance with 2600.144c1.

- To ensure consistent adherence to Regulation 2600.144c1, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

*Implemented* [REDACTED] - 06/17/2025)

## 183b - Meds and Syringes Locked

**8. Requirements**

2600.

183b Meds and Syringes Locked (continued)

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 [redacted] at approximately 10:14 AM, two tubes of [redacted] were unlocked, unattended, and accessible in resident [redacted] and resident [redacted] shared room in the Secure Dementia Care Unit.

On [redacted] at approximately 10:56 AM, [redacted] Halls cough drops, and [redacted] were unlocked, unattended and accessible in resident [redacted] room.

Plan of Correction

Accept [redacted] - 05/21/2025)

On 4/17/25, at time of survey, the healthcare director removed 2 tubes of [redacted] from the shared room of resident [redacted] and resident [redacted]

On 4/17/25, at time of survey, the healthcare director removed [redacted] Halls Cough drops and [redacted] from resident [redacted] room.

By 4/18/2025, the healthcare director or designee, audited remaining apartments for compliance to regulation, any further findings corrected at time of audit.

By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.183b and to report noncompliant findings to Healthcare Director or designee, documentation shall be kept.

Beginning 5/16/2025, the administrator or designee shall audit 5 memory care apartments and 5 personal care apartments for adherence with regulation. This audit shall occur weekly X 4 weeks.

To ensure consistent adherence to Regulation 2600.183b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [redacted] 06/17/2025)

183e - Storing Medications

9. Requirements

2600.

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

Description of Violation

On [redacted], a box of [redacted], with an expiration date of [redacted], was found in resident [redacted] bedroom.

Plan of Correction

Accept [redacted] - 05/21/2025)

On 4/17/25, the healthcare director removed the expired denture cleaner from resident [redacted] bedroom. The healthcare director contacted resident [redacted] responsible party to have denture cleaner replaced.

By 4/21/2025, the healthcare director or designee shall audit remaining apartments for expired personal care items, further findings to be addressed at time of audit.

By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.183e and to report noncompliant findings to healthcare director or designee, documentation shall be kept.

Beginning 5/15/2025, the Healthcare director or designee shall audit 5 resident apartments weekly X 4weeks for adherence with regulation.

**183e Storing Medications (continued)**

To ensure consistent adherence to Regulation 2600.183e, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [REDACTED] - 06/17/2025)

**225c - Additional Assessment****10. Requirements**

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

**Description of Violation**

Resident [REDACTED] most recent assessment, dated [REDACTED], does not include the resident's on going wandering and exit seeking behaviors. Resident [REDACTED] was initially admitted to the home under personal care on [REDACTED] but was moved to the home's Secure Dementia Care Unit (SDCU) after the resident attempted to leave the home three times on [REDACTED]. After the resident was moved to the SDCU, the resident has been observed multiple times by staff trying to leave the SDCU through the dining room door that led to the outside of the building.

Resident [REDACTED] most recent assessment, dated [REDACTED], does not include the resident utilizes a portable urinal, a powerlift recliner or a motorized scooter to ambulate within the home.

Resident [REDACTED] most recent assessment was on [REDACTED]

Repeated Violation [REDACTED] and [REDACTED] et al

**Plan of Correction**

Accept [REDACTED] - 05/23/2025)

On 4/17/25, at time of survey, the healthcare director amended resident [REDACTED] current RASP to include wandering behavior and appropriate interventions.

On 4/17/25, at time of survey, the healthcare director amended resident [REDACTED] current RASP to include use of recliner, portable urinal and motorized scooter.

On 4/17/2025, the healthcare director completed an assessment/support plan for resident [REDACTED]

By 4/21/2025, the healthcare director or designee to audit current resident assessments and support plans for accuracy and timely completion.

By 4/21/2025, the administrator shall educate the healthcare director on regulation 2600.225c. Documentation shall be kept.

Beginning 4/21/2025, the administrator or designee shall audit new assessments and support plans for accuracy and timely completion weekly X 4 weeks.

To ensure consistent adherence to Regulation 2600.225c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

225c - Additional Assessment (*continued*)

Licensee's Proposed Overall Completion Date: 06/16/2025

*Implemented* [REDACTED] - 06/17/2025)

## 233c - Key-Locking Devices

## 11. 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**

On [REDACTED], at approximately 9:50 AM, the directions for operating the home's locking mechanism were not conspicuously posted near the door adjacent to resident room [REDACTED] in the Secure Dementia Care Unit.

**Plan of Correction***Accept* [REDACTED] - 05/21/2025)

-On 4/17/25, at time of survey, the maintenance director conspicuously posted the operating directions (code) for the locking mechanism at the door adjacent to resident room [REDACTED]

-On 4/21/2025, the maintenance director audited remaining locking mechanisms, any further findings shall be addressed at time of audit.

-By 4/21/2025, the administrator shall educate the maintenance director on regulation 2600.233c, documentation shall be kept.

-By 5/29/25, the administrator shall educate current staff on regulation 2600.233c, documentation shall be kept.

-Beginning 4/21/2025, the administrator or designee shall audit key locking devices weekly X 4 weeks. Per TELS the maintenance director shall check functioning of locking devices/ placement of operating directions monthly, ongoing.

- To ensure consistent adherence to Regulation 2600.233c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

*Implemented* [REDACTED] - 06/17/2025)

## 233d - Electronic/Magnetic System

## 12. Requirements

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

**Description of Violation**

There is a door beside the kitchenette in the Secure Dementia Care Unit that exits to outside of the home. On the morning of [REDACTED], this door only latched closed three out of five times. On the afternoon of [REDACTED], this door only latched closed one out of four times.

233d - Electronic/Magnetic System (continued)

Plan of Correction

Accept [REDACTED] 05/21/2025)

- On 4/18/2025 the maintenance director adjusted the memory care door beside the kitchenette to ensure proper closure/latching.
- On 4/21/2025, the maintenance director checked the remaining outside exit doors to ensure proper operation.
- By 4/21/2025 the administrator shall educate the maintenance director on regulation 2600.233d, documentation shall be kept.
- Beginning 4/21/2025, the administrator or designee shall observe the outside exit doors weekly X4 weeks for proper closure.
- Beginning 5/19/25, per TEL's the Maintenance director shall observe exit doors for proper functioning monthly during building rounds.
- To ensure consistent adherence to Regulation 2600.233d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [REDACTED] - 06/17/2025)

251b - Record Entries Legible

13. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction tape was used on resident [REDACTED] preadmission screening, dated [REDACTED], the resident's assessment and support plan addendum, dated [REDACTED] and the resident's progress notes from [REDACTED]

Plan of Correction

Accept [REDACTED] 05/21/2025)

- Unable to correct documentation on resident [REDACTED]'s chart.
- By 5/29/2025, the administrator shall educate current staff on 2600.251b, documentation shall be kept.
- Beginning 4/21/2025, the administrator or designee shall audit 5 charts weekly X 4 weeks to ensure adherence to regulation.
- To ensure consistent adherence to Regulation 2600.251b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: 06/16/2025

Implemented [REDACTED] 06/17/2025)