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

February 13, 2026

[redacted]
ASBURY ATLANTIC
[redacted]

RE: BETHANY VILLAGE RETIREMENT CENTER
5225 WILSON LANE
MECHANICSBURG, PA, 17055
LICENSE/COC#: 33023

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/24/2025, 11/25/2025 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: *BETHANY VILLAGE RETIREMENT CENTER* **License #**: *33023* **License Expiration**: *06/27/2026*

Address: *5225 WILSON LANE, MECHANICSBURG, PA 17055*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *ASBURY ATLANTIC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/27/2005* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *130* **Waking Staff**: *98*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *11/25/2025*

Inspection Dates and Department Representative

11/24/2025 - On-Site: [redacted]

11/25/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *100*

Special Care Unit

In Home: *Yes* **Area**: *Golden Maple* **Capacity**: *30* **Residents Served**: *30*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *100*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

11/24/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/27/2025*

01/05/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/06/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/12/2026*

Inspections / Reviews *(continued)*

01/13/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/06/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/09/2026*

02/13/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/06/2026*

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

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labeled with the date of installation and be replaced at least once annually. On [redacted], the batteries in the CO alarm located in the kitchen had last been installed on [redacted].

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the approved CO alarm cannot be heard by the staff on duty on a specific floor or wing of the home, a single approved carbon monoxide alarm shall be installed where it can be heard by the staff on duty in addition to the alarm installed in close proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On [redacted], the CO alarm in the kitchen cannot be heard from floors 1-3, where the residents reside.

Repeated Violation - [redacted] et al

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/24/25 Dining General Manager immediately replaced the Carbon Monoxide battery (documentation attached)
On 12/01/25 Dining General Manager posted a laminated visual reminder for battery change on November of 2026.
On 12/4/25 Dining director and Director of Facilities met to develop a plan for annual battery replacement notification reminders within TELS work order system to alert every 6 months with battery replacement notification, testing of device, and exterior cleaning of device if needed. Documentation to be provided.
Facilities Director has requested quotes to have the carbon monoxide detector located in the west main kitchen hard wired into the carbon monoxide system within Assisted Living to ensure audibility of the device by residents and staff.
Director of Facilities reviews TELS alerts every 6 months and assigns battery replacement as needed. (Audit

1/6/26 In response to your questions:
On 11/25/25 AL administrator did inventory count of all CO detectors that require battery changes and determined that all other CO alarms are hardwired into alert system.
On 1/6/26 AL Administrator educated Director of Facilities and Dining Manager on regulation 2800 18. to ensure compliance of regulation moving forward. (Refer to document 2800.18 Education Completion Record)
Facilities director requested quote from approved vendor JCI on 12/22 and again on 1/5/26 and as of 1/6/26 the request was elevated for estimation and approval. Once approval is received, the vendor will be scheduled to hardwire the carbon monoxide detector into the assisted living system, with installation completed at the earliest available date
Start date for TELS audits to be completed every 6 months with scheduled date of May 2026. (Documentation of TELS work order to be attached)

Licensee's Proposed Overall Completion Date: *01/12/2026*

Implemented [redacted] - 02/09/2026)

82c Locked poisons

3. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted], a spray bottle of Skintegrity wound cleanser, a package of providone-iodine swab sticks and 5 tubes of Crest toothpaste, with manufactures' labels indicating "contact poison control center if ingested", were unlocked, unattended and accessible to residents in the storage closet located in the Secure Care Unit (SCU). None of the residents in the SCU have been assessed as capable of recognizing and using poisons safely.

On [redacted] at approximately 10:00 AM, a container of Kruder Kritter cleaner and degreaser as well as two cans of paint with manufactures' labels indicating, "contact poison control center if ingested" were unlocked, unattended and accessible to residents on a large cart in the hallway of the SCU. None of the SCU residents have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept[redacted] 01/13/2026)***

On 11/24/25 AL administrator immediately secured the closet door lock.
All other secured areas containing poisons were reviewed and found secure. On 11/26/25 Maintenance assessed the door and lock to ensure proper function. On 12/1/25 remaining poisons and wound care items were removed and stored in a secured location.

On 11/25/25 AL administrator reminded the vendor of the requirement to maintain possession of poisonous substances while working in Memory Support. The contractor corrected the issue immediately and the incident was reported to the supervisor.
Vendor sign-in documentation was updated to include locked-poison expectations.
Monitoring: Vendor compliance reviewed upon sign-in and during active work as needed.

1/6/26 In response to your questions:
On 12/1/25 AL Administrator removed and stored the remaining poisons and wound care items.
On 1/6/26 Weekly Audits to be initially performed by AL administrator weekly for 2 weeks then to be completed by AL administrator monthly starting on 1/26/26 to ensure compliance. (Audit log 82c. to be attached)

Proposed Overall Completion Date: 01/26/2026

Proposed Overall Completion Date: 01/26/2026

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] 02/09/2026)

85a Sanitary conditions

4. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

85a Sanitary conditions *(continued)*

Description of Violation

On [redacted], the raised toilet seat, the toilet and the cross bar of the raised toilet seat located in resident room [redacted] was splattered with dried brown fecal matter.

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/24/25 AL Administrator contacted Housekeeping Manager to immediately clean the fecal matter in room 235.
On 11/25/25 Housekeeping Manager performed rounds and no further fecal matter was identified.
On 11/26/25 Housekeeping Manager spoke with the resident and provided direct contact information.
Monitoring: Housekeeping Manager will conduct a weekly spot check of resident bathrooms and common area restrooms in the affected neighborhood and follow up on concerns.

1/6/26 In response to your questions:
On 1/6/26 AL Administrator educated Housekeeping Manager and Housekeeping Staff on regulation 85a. to ensure compliance of regulation moving forward. (Refer to document 2800. 85a Education Completion Record)
Weekly Audits to begin on 1/12/26 by Housekeeping Manager

Proposed Overall Completion Date: 01/26/2026

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

103c Food protected

5. Requirements

2800.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On [redacted], there were 5 large trays of uncovered food, including wild rice, chicken and gravy that were stored in the kitchen freezer.

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/24/25 Dining Manager and Executive Chef immediately covered, labeled, and dated uncovered food items. All kitchen areas were assessed with no additional concerns found.
On 11/26/25 Dining leadership developed staff training on labeling and dating. Any food and/or beverage items found without proper wrapping, labeling, dating, and initialing will be corrected immediately and reported to the Dining Manager and/or Executive Chef for follow up.
Monitoring: Dining Manager and Executive Chef will complete weekly spot checks of refrigerators, freezers, pantries, and prep areas for proper covering/labeling/dating and follow up on concerns.

1/6/26 In response to your questions:
On 11/26 27/25 staff were educated after training plan was developed during their all staff meetings.
Weekly audits initiated by Dining Manager and Executive Chef on 12/08/25

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented [redacted] - 02/13/2026)

121a Unobstructed egress

6. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On [redacted] at 1:55 PM, the C17 doorway between the Secure Care Unit dining room and the enclosed courtyard was blocked with a large planting station, preventing the door from opening completely.

Plan of Correction ***Accept [redacted] - 01/13/2026)***

Door C17 is not a designated egress door as indicated by posted signage.
On 11/24/25 AL administrator relocated the planting station to ensure unobstructed access. AL administrator assessed all other doors and exits in secure neighborhood to ensure all pathways remain unobstructed.
Routine rounds by AL administrator or designee to ensure exits and pathways remain unobstructed.

1/6/26 In response to your questions:
On 11/24/25 AL administrator assessed all other doors and exits in secure neighborhood to ensure all pathways remain unobstructed. No designated egress doors are obstructed facility-wide.
On 1/6/26 AL administrator educated SCU staff on maintaining unobstructed doorways
On 1/6/26 Weekly audits initiated and to be completed weekly by AL administrator

Proposed Overall Completion Date: 01/26/2026

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

171b5 Transportation-first aid kit

7. Requirements

2800.
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 § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

Description of Violation

The first aid kit in the Toyota minivan and Ford F450 shuttle bus, used to transport residents, were not equipped with a breathing shield and antiseptic.

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/24/25 AL Administrator immediately ordered the appropriate breathing shield and antiseptic for vehicles which were received on 12/1/25.
On 12/19/25 AL administrator stocked and secured the kits. Drivers to report any opened kits to AL administrator for resupply.
Monthly vehicle first aid kit checks by AL administrator or designee.

1/6/26 In response to your questions:
On 01/06/26 Drivers and Transportation Supervisor were educated by AL Administrator on regulation 171b and need to report any opened kits to AL Administrator.
Monthly First Aid Kit audits started on 1/5/26

171b5 Transportation-first aid kit *(continued)*

Licensee's Proposed Overall Completion Date: *01/07/2026*

Implemented [redacted] - 02/13/2026)

183b Medications and syringes locked

8. Requirements

2800.
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 living unit.

Description of Violation

On [redacted] at 1:46 PM, Resident [redacted] bathroom cabinet drawer was not affixed to the tracks and easily fell out when opened. This exposed the prescribed [redacted] in the drawer below, along with other hygiene supplies. Resident [redacted] resides in the Secure Care Unit and is not assessed as being able to self-administer [redacted] medications.

On [redacted] at 2:35 PM, [redacted] and [redacted] were unlocked, unattended, and accessible in Resident [redacted] bathroom. Resident [redacted] is not assessed as being able to self-administer [redacted] medications.

Resident [redacted] self-administers all of [redacted] medications and stores them throughout [redacted] room and bathroom in unlocked locations. Resident [redacted] reports [redacted] never locks [redacted] bedroom door when [redacted] leaves [redacted] room and has never locked [redacted] mediations in a locked area in [redacted] room.

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] - 01/13/2026)***

Resident [redacted] (SCU) On 11/24/2025 bathroom cabinet drawer was fixed immediately by Maintenance team. Nursing staff completed a full neighborhood inspection and found all other drawers to be securely locked.
Nursing staff are to do rounds beginning and end of shift to ensure all drawers are locked and on track and report any issues to DON and AL administrator.

Resident[redacted] and [redacted]: On 11/24/2025-Director of Nursing immediately locked up all medications in secured area provided by home. DON assessed all other resident apartments that self-administer medications and found no other unsecured medications. Director of Nursing will educate any residents who self-administer medications on compliance related to securing medications at all times.
Director of Nursing provided education to all support staff on their duty to report medications not maintained in a secure area by residents that self-administer per physicians' orders.
Director of Nursing or designee will conduct a monthly spot check of apartments for residents who self administer medications, or identified at-risk residents) to confirm secure storage and follow up on concerns.

1/6/26 In response to your questions:
-On 11/24/25 audit was completed to ensure all other drawers were secured
-Daily rounds to ensure all drawers are secure started on 11/25/26
-DON assessed all other resident apts. who self administer on 11/24/25 and audited all other apts. for residents who do not self administer 11/24/25-11/26/25.
-DON to provide ongoing education to self administering residents on 1/12/26

183b Medications and syringes locked (continued)

DON provided education to all staff on 12/03/25 and again on 1/7/26
DON will initiate monthly audits on 1/12/26

Proposed Overall Completion Date: 01/26/2026

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

183d Current medications

9. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On [redacted] at 2:35 PM, [redacted] and [redacted] cream were unlocked, unattended, and accessible in Resident [redacted] bathroom. However, there are no current orders for the eye drops or cream.

Plan of Correction ***Accept ([redacted] - 01/13/2026)***

On 11/24/2025 DON immediately removed medications from resident's apartment and all self administering apartments were assessed and found no other unsecured medications or medications without physician's orders on file. Director of nursing will educate residents and family members that any medications brought to community must have a physician's order and assessment to determine safety to utilize medication and the ability to maintain securely in apartment.
Director of nursing or designee completes monthly spot check of self administering apartments to confirm medications have current physician orders and are stored securely.

1/6/26 In response to your questions:
Resident and family member education provided on 1/12/26
Education completed on 12/3/25 and again on 1/7/26 to nursing staff by DON and AL Administrator
DON will initiate monthly audits on 1/12/26

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

184a Resident meds labeled

10. Requirements

2800.
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

The pharmacy label for Resident [redacted]

184a Resident meds labeled (continued)

's prescribed [redacted] states to inject [redacted] subcutaneously. However, the prescriber's order states to inject [redacted] subcutaneously. The label does not include a change of order sticker.

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/25/2025 DON and licensed nurse immediately put a change of direction label on the insulin pen.
On 11/25/25 the Six Steps to Safe Medication Administration was reviewed with appropriate staff member as this appeared to be an isolated violation as no other medications were found to be unlabeled with medication changes.
Director of Nursing or designee verifies labeling during monthly medication/cart checks or routine medication reviews.

1/6/26 In response to your questions:
-DON will initiate monthly audits on 1/12/26

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

185a Storage procedures

11. Requirements

2800.
185.a. The residence 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 [redacted] is prescribed [redacted] table and [redacted] as needed. However, on [redacted] these medications were not available in the home.

Resident [redacted] is prescribed [redacted] as needed. However, on [redacted], this medication was not available in the home.

Resident [redacted] is prescribed blood sugar checks four times per day with a [redacted], and the resident is prescribed [redacted] based on a sliding scale. However, individual readings are not retained in Resident [redacted] glucometer to verify the [redacted] was administered as prescribed.

Resident [redacted] is prescribed blood sugar checks four times per day with a [redacted], and the resident is prescribed [redacted] based on a sliding scale. However, individual readings are not retained in Resident [redacted]s glucometer to verify the [redacted] was administered as prescribed.

Resident [redacted] is prescribed Senna as needed. However, on [redacted], this medication was not available in the home.

185a Storage procedures (continued)

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/25/25 PRN medications were reordered and delivered. PRN access is ensured through pharmacy and on-site Pyxis. Dexcom monitoring was discontinued and finger stick monitoring implemented.

Resident [redacted] Resident infrequently requests PRN medication prescribed but resident requests PRN order remain active in the event that resident would need it. Nursing would utilize on-site Pyxis to obtain PRN medication upon resident request.
Resident [redacted]: Will provide photocopy of medication card that was present during cart inspection
DON or designee completes a monthly review confirming PRN availability and glucose documentation supports insulin administration.

1/6/26 In response to your questions:
-Education completed on 12/3/25 and again on 1/7/26 by DON and AL Administrator
-DON will initiate monthly audits on 1/12/26

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)

187d Follow prescriber's orders

12. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] with orders to instill 1 drop in both eyes two times a day at 6:00 AM and 4:00 PM. However, this medication was not administered on [redacted] at 4:00 PM, on [redacted] at 6:00 AM and on [redacted] at 4:00 PM.

Repeated Violation - [redacted], et al

Plan of Correction ***Accept [redacted] - 01/13/2026)***

On 11/26/25 Director of nursing reviewed medication administration records to confirm medications were administered per prescribed orders. Licensed nursing staff were reminded to immediately report missed doses or discrepancies.
Director of Nursing or designee to complete monthly MAR spot check for compliance with prescribed orders.

1/6/26 In response to your questions:
-Education completed on 12/3/25 and again on 1/7/26 by DON and AL Administrator
-DON will initiate monthly audits on 1/12/26

187d Follow prescriber's orders (continued)

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] 02/13/2026)

191 Resident right to refuse

13. Requirements

2800.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

The following residents, admitted on the following days, have not been educated on the resident's right to refuse medication if the resident believes that there may be a medication error:

- *Resident [redacted] admitted on [redacted]*
- *Resident [redacted] admitted on [redacted].*
- *Resident [redacted] admitted on [redacted]*

Plan of Correction ***Accept ([redacted] - 01/13/2026)***

On 11/26/25: Residents identified during the inspection were educated regarding their right to question or refuse medications if they believe a medication error may exist. Documentation of resident education was completed and placed in the resident record. Education regarding the right to refuse medication will be provided upon admission and documented moving forward.

Social Worker will complete full house audit identifying any residents in need of education and documentation will be provided in residents chart. Social worker will review residents rights regarding refusal of medication as part of the admission process for all new admissions moving forward. Compliance regarding education will be reviewed on a weekly basis during the Admission Team Meeting.

1/6/26 In response to your questions:
-On 11/26/25 Education was completed by AL Administrator to Social Worker and Admissions Director to ensure compliance moving forward.
-Initial Audit to be completed by 1/12/26 by Social Worker
-Weekly Audits to begin on 1/12/26 during Admission Team Meeting with DON, SW, and nursing team

Licensee's Proposed Overall Completion Date: *01/12/2026*

Implemented [redacted] 02/13/2026)

233b Lock manufact. statement

14. Requirements

2800.
233.b. A residence shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.

233b Lock manufact. statement *(continued)*

3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The residence uses electronic magnetic locking devices on the doors of the Secure Care Unit. The letter from Tyco Simplex Grinnell, dated 6/15/07, does not include a statement verifying that the electronic magnetic locking system will release when the fire alarm system is activated, the residence's power fails, and when the lock releasing device is operated.

Plan of Correction ***Accept (- 01/13/2026)***

AL Administrator immediately made Facilities Manager aware of the issue.
The Facilities Manager requested on behalf of the residence updated documentation from the manufacturer verifying that the electronic magnetic locking system releases upon fire alarm activation, power failure, and use of the lock releasing device. Manufacturer documentation will be maintained on site and available for review.

1/6/26 In response to your questions:
Education provided by AL Administrator to Facilities Manager on 1/7/26 regarding citation 233b (Documentation of education on 233b to be attached).
Updated Letter was requested on 12/2/25 and 12/8 with contact made with vendor JCI on 12/17 and again on 12/30. As of 1/7/26 JCI is scheduled to come out week of 2/2/2026 for follow up inspection and to provide updated letter of documentation needed. AL will ensure that letter of compliance is obtained by vendor.
Ongoing monitoring of this documentation to be completed annually during Facilities and AL Administrator annual update meeting scheduled on 10/5/26, Director of Facilities will monitor that documentation is upheld and available prior to and during 10/5/26 meeting.

Licensee's Proposed Overall Completion Date: *02/06/2026*

Implemented - 02/09/2026)

233c Key-locking devices

15. Requirements

2800.
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 , the directions for operating the residence's locking mechanism were not conspicuously posted near door C16, door C17, and door C18 in the Secure Care Unit.

Plan of Correction ***Accept (- 01/13/2026)***

AL administrator immediately posted door codes at all doors entering the Memory Support Courtyard and exteriorly on those doors to re enter the neighborhood from the enclosed courtyard.
AL administrator assessed all other doors exiting Memory Support neighborhood and ensured that all codes were posted.
AL administrator is responsible to post all door codes when codes are changed for safety and security reasons. Facilities director will ensure door codes are posted during monthly inspections.

1/6/26 In response to your questions:

233c Key locking devices (continued)

Initial audit was completed on 11/24/25 by AL Administrator
Director of Facilities was educated on citation 233c on 1/7/26 by AL Administrator for ongoing compliance.
Monthly audits to be initiated by AL Administrator or Director of Facilities on 1/12/26

Proposed Overall Completion Date: 01/26/2026

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 02/13/2026)