pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **MORNINGSIDE HOUSE OF EXTON, LLC**
LEGAL ENTITY

To operate **MORNINGSIDE HOUSE OF EXTON**
NAME OF FACILITY OR AGENCY

Located at **200 SUNRISE BOULEVARD, EXTON, PA 19341**
(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 **106**
(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 39**

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 **June 19,** **2026** until **June 19,** **2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **151350**

ISSUING OFFICER

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 628 – 04/23

Pennsylvania
Department of Human Services

Emailing Date: June 30, 2026

[redacted]
Regional Director of Operations
Morningside House of Exton, LLC
[redacted]
[redacted]

RE: Morningside House of Exton
200 Sunrise Boulevard
Exton, Pennsylvania 19341
License #: 151350

[redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on April 13 and 14, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

June 25, 2026

[redacted]
MORNINGSIDE HOUSE OF EXTON, LLC
[redacted]

RE: MORNINGSIDE HOUSE OF EXTON
200 SUNRISE BOULEVARD
EXTON, PA, 19341
LICENSE/COC#: 15135

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/13/2026, 04/14/2026 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: *MORNINGSIDE HOUSE OF EXTON* **License #**: *15135* **License Expiration**: *06/19/2026*

Address: *200 SUNRISE BOULEVARD, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MORNINGSIDE HOUSE OF EXTON, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/04/1999* **Issued By**: *COPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *78* **Waking Staff**: *59*

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date**: *04/14/2026*

Inspection Dates and Department Representative

04/13/2026 - On-Site [redacted]

04/14/2026 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *39* **Residents Served**: *13*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *46*

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

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

04/13/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2026*

06/04/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/22/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/14/2026*

Inspections / Reviews *(continued)*

06/18/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/22/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/23/2026*

06/25/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/22/2026*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted], at 12:45 PM, an agent of the Department, requested access to staffing records. Staff person A did not provide complete staffing records until [redacted] at 10:32 AM.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Staff person A transitioned from a management role to a PRN position on April 8 2026 and removed [redacted] files without authorization. [redacted] was contacted on 4.13.26 and provided [redacted] file on 4.14.26 at which time it was presented to the Department.
All files are kept secured in the management office with access limited to management staff for confidentiality. On April 14, 2026 Administrator reviewed the requirement for immediate access to records with all management staff. By June 5 2026, the administrator will provide education to all management staff, shift supervisors, and reception personnel will receive education regarding 2600.5(a) requirements for immediate access to the home, residents, and records upon request by Department agents.
The Administrator or designee will conduct quarterly mock survey audits beginning in May 2026 to verify required records are immediately accessible. Findings will be reviewed through the facility Quality Assurance process by the administrator throughout 2026.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Evidence of Completion ***Implemented [redacted] 06/18/2026)***

See attached.

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident [redacted] was not signed by the resident. There was no indication the resident was given the opportunity to sign.

The resident-home contract, dated [redacted] for resident [redacted] was not signed by the resident. There was no indication the resident was given the opportunity to sign.

Plan of Correction ***Accept ([redacted] 06/04/2026)***

Resident [redacted] and Resident [redacted] contracts were reviewed on 4.15.26 with residents, who were offered an additional opportunity to sign the contracts and documentation was completed regarding signature status.
An audit of all current resident contracts was completed to verify signatures of residents, designated persons, and administration as required by administration on 4.24.26
Admissions staff and administration were educated on April 28 2026 re 2600.25(b) requirements including documentation when a resident declines or is unable to sign.

25b Contract Signatures (continued)

The Administrator/designee will audit all new admissions and contract renewals within 24 hours of move in to ensure documentation is completed. Compliance will be reported by the administrator beginning in May 2026 through the Quality Management Plan review throughout 2026.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

65d Initial Direct Care Training

3. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person B, hired on [redacted] began providing unsupervised ADL services on [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted].

Plan of Correction ***Accept ([redacted] - 06/04/2026)***

Staff person B was immediately removed from unsupervised direct care duties until completion of all required Department-approved training and competency testing, which was completed on 4.14.26.

An audit of all direct care employee files was completed by administration on 4.24.26 to verify completion of orientation, competency testing, and required training prior to unsupervised assignment.

Department managers and coordinators were educated on 4.28.26 regarding 2600.65(d) requirements prohibiting unsupervised ADL care until successful completion of all required training.

65d - Initial Direct Care Training (continued)

The Employee Relations and Administrative Coordinator will review all new hire files for compliance before notifying the scheduling manager that a new employee is able to be scheduled for a regular work assignment beginning May 2026. Quarterly audits will be completed by the administrator or designee beginning May 2026 through the Quality Management Plan to ensure ongoing compliance and continue through 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person C did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year [redacted]

Plan of Correction ***Accept [redacted] 06/04/2026)***

Staff person C completed training regarding resident assessments, support plans, and preadmission screening requirements by May 10 2026.
The 2026 Staff Training plan was reviewed on 4.24.26 by administration to ensure all mandatory topics are scheduled for staff
The Employee Relations and Administrative Coordinator will conduct monthly compliance audits for mandatory topics beginning May 2026. Department heads will remove non-compliant team members from the schedule after a 30 day grace period until training is completed.
Monthly audits of staff education records will be conducted and maintained by the administrator beginning May 2026 through the quality management plan throughout 2026 to ensure all annual training requirements are completed timely.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] 06/18/2026)***

See attached.

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff orientation training for in house employees does not include length of each course.

The home's record of direct care staff orientation training for agency/substitute employees does not include length and source of each course.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

The Agency Onboarding Form was updated to include course lengths, sources, and required documentation elements.
Administration and training personnel were educated regarding documentation requirements for all orientation and annual training records on 4.14.26
Monthly audits of training documentation will be completed by Employee Relations and Administration Coordinator beginning May 2026 and monitored quarterly through the Quality Management Plan Process by administrator beginning May 2026 throughout 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

85d - Trash Receptacles

6. 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

On [redacted] at 10:38 AM there was two full, uncovered, unattended trash can in the main kitchen.

Plan of Correction ***Accept [redacted] 06/04/2026)***

The uncovered trash receptacles in the kitchen were immediately covered appropriately.
Dietary staff were immediately educated regarding the requirement to keep trash cans covered when not in use. A comprehensive training on sanitation and infection prevention requirements will be provided to all dietary staff on 5.20.26 related to covered trash storage.
Beginning May 20 2026, daily kitchen sanitation rounds will be completed by dietary management with weekly environmental audits by administration and or designee. Compliance will be monitored quarterly beginning May 2026 ongoing throughout 2026 by the administrator through the quality management program.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

96b - First Aid Location

7. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

On [redacted] staff persons D and E did not know the location of the first aid kit.

Plan of Correction ***Directed ([redacted] - 06/04/2026)***

Staff persons D and E were immediately educated regarding the location of the facility first aid kit.
All team members will be re-educated by the administrator on the location of the first aid kits at Town Hall on June 5 2026.
First aid location has been added to the fire safety orientation conducted by the Plant Operations Supervisor conducted during the first day of orientation.

Directed Plan of Correction [redacted] 6/4/26):
In addition to the steps submitted in the Plan of Correction, the administration will add the following steps, starting immediately:
1. The administrator will discuss the location of the first aid kits at each monthly staff meeting for the next six months.

Proposed Overall Completion Date: 06/14/2026

Directed Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

103g - Storing Food

8. Requirements

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

Description of Violation

On [redacted] 5 gallons of ice cream in the freezer were opened and unsealed.

Plan of Correction ***Accept[redacted] 06/04/2026)***

The opened ice cream containers were sealed appropriately at the time of the survey.
New silicone ice cream lids have been purchased to ensure adequate fit.
Dietary staff were immediately educated regarding the requirement. A comprehensive training on food storage requirements will be provided to all dietary staff on 5.20.26 related to covered trash storage.
Beginning May 20 2026, daily kitchen sanitation rounds will be completed by dietary management with weekly environmental audits by administration and or designee. Compliance will be monitored quarterly beginning May 2026 ongoing throughout 2026 by the administrator through the quality management program.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

103i - Outdated Food

9. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On [redacted] there was an unlabeled, undated ketchup, mustard and chocolate syrup in the main kitchen refrigerator.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Undated items had been purchased for a recent community event, and were discarded immediately.
A complete refrigerator and pantry audit was completed by the dining director on 4.14.26 to ensure all opened food items were properly labeled and dated.
Dietary staff were immediately educated regarding the requirement. A comprehensive training on food storage requirements will be provided to all dietary staff on 5.20.26 related to covered trash storage.
Beginning May 20 2026, daily kitchen sanitation rounds will be completed by dietary management with weekly environmental audits by administration and or designee. Compliance will be monitored quarterly beginning May 2026 through 2026 by the administrator through the quality management program

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] 06/18/2026)***

See attached.

183d - Prescription Current

10. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] [redacted] prescribed for resident[redacted] was in the home's medication cart; however, the home does not have an order for this medication.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

The medication was immediately removed from active medication storage pending clarification of physician orders.
A medication cart audit was completed on April 24 2026 by the regional director to ensure all medications maintain had current physician orders.
Medication administration staff will complete re training on medication storage requirements and verification of current physician orders by June 5 2026.
Monthly cart audits will completed by nursing staff starting May 2026. Full cart audits will completed by the Health and Wellness Director or pharmacy provider quarterly and results will be monitored by the administrator quarterly through the quality management program through 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

183e Storing Medications

11. Requirements

2600.

183e - Storing Medications *(continued)*

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] there was a loose white oblong pill in the home's memory care medication cart.

Repeat violation [redacted] et al

Plan of Correction ***Accept ([redacted] 06/04/2026)***

The unidentified loose medication was immediately removed and disposed of per facility policy.
A medication cart audit was completed on April 24 2026 by the regional director to ensure all medications were secure in their blister packaging.
Medication administration staff will complete re-training on medication storage requirements by June 5 2026.
Monthly cart audits will completed by nursing staff starting May 2026. Full cart audits will completed by the Health and Wellness Director or pharmacy provider quarterly and results will be monitored by the administrator quarterly through the quality management program through 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] - 06/18/2026)***

See attached.

185a - Implement Storage Procedures

12. 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

On [redacted] at 08:24 AM resident [redacted] medication administration record indicated that a reading of [redacted] was taken on [redacted] glucometer. This reading was not found in the resident's glucometer.

Plan of Correction ***Accept [redacted] 06/04/2026)***

The glucometer for resident [redacted] was not consistently registering or saving blood sugar levels, and a new glucometer was ordered from the pharmacy on 4.14.26.
An audit of diabetic residents' glucometer readings and MAR documentation was conducted on 4.24.26 to verify accuracy and consistency
Medication administration staff will complete re-training on glucometer management and documentation requirements by the Health and Wellness Director or designee by June 5 2026.
Monthly cart audits will completed by nursing staff starting May 2026. Full cart audits will completed by the Health and Wellness Director or pharmacy provider quarterly and results will be monitored by the administrator quarterly starting in May 2026 through the quality management program through 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented [redacted] 06/18/2026)***

See Attached

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident [redacted] is prescribed glucometer readings to be taken at 8:30 AM, 11:30 AM and 4:30 PM and for an injection of [redacted] for blood sugar readings: 150-200= 2u, 201-250= 4u, 251-300=6u, 301-350=8u, 351-400= 10u, >401=12u. Resident [redacted] is also prescribed a straight order of [redacted] prior to each meal. On [redacted] resident [redacted] medication administration record (MAR) had a reading of [redacted] however this reading was not found in resident [redacted] s glucometer.

On [redacted] and [redacted] resident [redacted] did not receive [redacted] because it was not available in the home.

Resident [redacted] is prescribed [redacted] tablet chew, take tablet by mouth once daily starting [redacted]. According to resident's [redacted] MAR this medication was not administered from [redacted] because it was not added to the MAR until [redacted]. The medication was available in the home.

Plan of Correction ***Directed [redacted] - 06/04/2026)***

Medication orders and MARs for Residents [redacted] and [redacted] were immediately reconciled. Missing medications were obtained and administration procedures corrected.
Medication administration staff will complete re-training on following prescriber orders and documentation requirements by the Health and Wellness Director or designee by June 5 2026.
Monthly cart audits will be completed by nursing staff starting May 2026. Full cart audits will be completed by the Health and Wellness Director or pharmacy provider quarterly and results will be monitored by the administrator quarterly starting in May 2026 through the quality management program through 2026.

Directed Plan of Correction ([redacted]6//4/26):
In addition to the steps submitted in the Plan of Correction, the following steps will be implemented immediately:
1. The administrator will order a new glucometer for resident #4 to ensure the correct readings are obtained and recorded on the MAR.
2. The Director of nursing will review the glucometer logs at least weekly for the next 4 weeks to ensure the glucometers and the staff are recording the glucometer readings correctly.
3. The administrator will review the glucometer readings at least monthly for the next four months to ensure the staff are documtning the correct glucometer readings.

Proposed Overall Completion Date: 06/14/2026

Directed Completion Date: *06/14/2026*

Evidence of Completion ***Not Implemented[redacted] 06/18/2026)***

See attached.

Evidence of Completion ***Implemented [redacted] - 06/25/2026)***

See attached.

225c - Additional Assessment

14. 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.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] utilizes a halo bedside mobility device to aid in transfers.
Resident [redacted] assessment, dated [redacted] does not include the need and purpose of the device.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Resident 6's assessment and support plan were updated to include the bedside mobility device and associated care needs.
An audit of resident assessments was completed on 4.24.26 to verify inclusion of adaptive equipment and transfer assistance needs.
The Health and Wellness Director was educated on assessment update requirements when resident conditions or equipment needs change on 4.20.26. All Health and Wellness team members will be educated regarding the need to monitor and communicate changes in equipment by June 5 2026
Quarterly assessment audits will be conducted beginning in May 2026 by the Health and Wellness Director or designee to ensure ongoing accuracy and completeness. Audits will be monitored by the administrator quarterly through the quality management program through 2026.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Implemented ([redacted] - 06/18/2026)***

See attached.

236 - Staff Training

15. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of training in dementia care during the [redacted] to [redacted] training year.

Plan of Correction ***Accept [redacted] - 06/04/2026)***

Staff person C completed the deficient dementia-specific training hours required for Secure Dementia Care Unit staff by May 10 2026.
The 2026 Staff Training plan was reviewed on 4.24.26 by administration to ensure all mandatory topics and required hours are scheduled for staff

236 - Staff Training (continued)

The Employee Relations and Administrative Coordinator will conduct monthly compliance audits beginning in May 2026 for mandatory topics and training hours. Department heads will remove non-compliant team members from the schedule after a 30 day grace period. Compliance will be monitored quarterly beginning May 2026 by the administrator through the quality management plan throughout 2026 to ensure all annual training requirements are completed timely.

Licensee's Proposed Overall Completion Date: *06/14/2026*

Evidence of Completion ***Not Implemented [redacted] - 06/18/2026)***

See attached.

Evidence of Completion ***Implemented [redacted] - 06/25/2026)***

See attached.