

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

October 22, 2026

[REDACTED] EXECUTIVE DIRECTOR
CHRISTIAN RESIDENTIAL OPPORTUNITIES & SOCIAL SERVICES INC
[REDACTED]

RE: GRIFFITH HOUSE
1345 APPLE WAY
ST THOMAS, PA, 7252
LICENSE/COC#: 36335

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/01/2026 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: GRIFFITH HOUSE

License #: 36335

License Expiration: 09/28/2027

Address: 1345 APPLE WAY, ST THOMAS, PA 7252

County: FRANKLIN

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: CHRISTIAN RESIDENTIAL OPPORTUNITIES & SOCIAL SERVICES INC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-3 SP

Date: 06/12/1997

Issued By: Department of Labor & Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 6

Waking Staff: 5

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 09/01/2026

Inspection Dates and Department Representative

09/01/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 6

Residents Served: 6

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 2

Are 60 Years of Age or Older: 2

Diagnosed with Mental Illness: 6

Diagnosed with Intellectual Disability: 6

Have Mobility Need: 0

Have Physical Disability: 0

Inspections / Reviews

09/01/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/01/2026

10/02/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/12/2026

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/09/2026

Inspections / Reviews (*continued*)

10/06/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/12/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/13/2026

10/22/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/12/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 9/1/26, at 10:44AM, Resident #1's vaccination record and workplace injury claim from [REDACTED], with a description of [REDACTED] accident and medical services rendered, were unlocked, unattended and accessible on the staff desk located in the dining room.

Plan of Correction

Accept ([REDACTED] - 10/06/2026)

On 9/1/2026, in the afternoon after the inspection took place, [REDACTED] (House Parent) moved the incorrectly placed information for Resident 1 back into [REDACTED] main file. The mine file was then locked and returned to the locked office.

On 9/22 a audit was completed of all common spaces at Griffith to ensure no confidential records were posted inappropriately. (attached) This was completed and signed by [REDACTED] (Director) and [REDACTED] (Administrator)

On 9/23 a training was conducted for the staff; The nature of this training was to ensure that all staff have the knowable that all resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

All staff attended and signed as shown in the attached document. (Staff names: [REDACTED] [REDACTED] [REDACTED] [REDACTED] and [REDACTED])

On 9/23 an monthly audit was implemented: the audit includes a monthly site check to ensure no records are posted incorrectly. (attached) The homes House Parent ([REDACTED]) is responsible for this audit.

Licensee's Proposed Overall Completion Date: 10/02/2026

Implemented ([REDACTED] - 10/14/2026)

26b - Quality Management Plan Content

2. Requirements

2600.

- 26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
 2. Complaint procedures.
 3. Staff person training.
 4. Licensing violations and plans of correction, if applicable.
 5. Resident or family councils, or both, if applicable.

26b - Quality Management Plan Content (continued)

Description of Violation

The home's quality management review dated 12/1/25 did not address the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Plan of Correction

Accept ([REDACTED] - 10/06/2026)

On 9/28/26 the 2025 QM Plan was reviewed to meet RCG requirements. (attached) [REDACTED] (Director), [REDACTED] (Admin) and [REDACTED] (House Parent) reviewed the QM Plan on 9/28/26.

QM Plan review paperwork (attached)

On 9/28/26 a training took place between the agency director and the home's leadership to ensure all have the knowledge of requirements of a QM Plan annual review.

An annual review audit was implemented and will be reviewed and signed each December to ensure an annual review of the QM Plan was completed for the year in review. [REDACTED] the homes Admin, is responsible for the annual audit. The attached 2025 QM; the audit and responses are included in red letters.

Licensee's Proposed Overall Completion Date: 10/02/2026

Implemented ([REDACTED] - 10/14/2026)

60a - Staff/Support Plan

4. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 8/3/26, 8/7/26, 8/8/26 8/9/26, 8/27/26 and 8/28/26 from 11:00PM to 7:00AM, there were no staff trained in medication administration present in the home. As a result, the home was unable to provide medication administration services during this time. There are no scheduled medications at the home during this time; however, Resident #2 is prescribed [REDACTED] (PRN) for [REDACTED]

Plan of Correction

Accept ([REDACTED] - 10/06/2026)

On 9/7/26 the staff listed above completed a full medication class and is now has a current certification (attached)

9/23 A training was completed for the House Parent [REDACTED] and Medical Coordinator ([REDACTED] (attached). This was completed by [REDACTED] (Agency Director)

9/23 a audit was completed to ensure all staff were up to date on their med certs (attached) This was completed and signed by [REDACTED] (Director)

60a - Staff/Support Plan (continued)

9/23 a monthly check was implemented so a monthly review is completed to ensure that all staff certifications remain up to date. This is the responsibility of the homes House Parent () and/or Homes Admin ()

Licensee's Proposed Overall Completion Date: 10/02/2026

Implemented () - 10/22/2026)

63a - First Aid/CPR Training

5. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/25/26, from 7:00AM to 9:00PM, 6 residents were present in the home. During this time, there were no staff present who were certified in CPR and First Aid.

Plan of Correction

Accept () - 10/06/2026)

On 9/8/26 the staff listed above completed CPR/1st aid training with the Red Cross. (attached)

On 9/24 a training was completed for the leadership at Griffith House to ensure all have the knowledge of CPR requirements. (attached) - () (Director and Red Cross Trainer) was responsible for educating the leadership () and () Education that took place included that staff need to be both CPR and First Aid certified, not just CPR certified as all that we teach from Red Cross at Cross, Inc in r.26 CPR/First Aid (this includes both CPR and 1st Aid).

Also a audit was completed of all current staff CPR certs (attached)

A monthly audit was implemented to ensure no staff lapses on their CPR requirements. (attached) This is the responsibility of the homes House Parent () and/or Homes Admin ()

Licensee's Proposed Overall Completion Date: 10/02/2026

Implemented () - 10/14/2026)

65e - 12 Hours Annual Training

6. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff Member B did not meet the required hours of annual training in training year 2025.

Plan of Correction

Accept () - 10/06/2026)

At Cross, Inc two of our homes typically do their staff training together due to the close location of the homes.

65e - 12 Hours Annual Training (continued)

(Grace Home and Griffith House)

██████████ 2025 training calendar was filed incorrectly at Grace Home in Grace Home's training file. This was discovered after the licensing inspection and was not available for inspectors at the time of inspection.

██████████ 2025 training calendar is attached. Refiled at Griffith House

9/24 a training was completed with the leadership at Griffith House to ensure all have the knowledge of the annual training requirements and appropriate filing. (attached) This was completed by ██████████ (Director) The training was given by ██████████ (director) to the House Parent (██████████) and the Homes Admin (██████████)

A audit was completed of all 2026 training calendars to ensure they are filed correctly. (Attached) This was completed by ██████████ (Director)

On 10/5 An audit of all 2025 annual trainings was completed to ensure all 2025 training files for all applicable staff are filed correctly. This was completed by ██████████ (Director) This is attached.

On 10/5 a monthly audit was implemented of all training calendars to ensure they are filed appropriately. This monthly audit is to be completed by ██████████ (House Parent) or ██████████ (Admin) This is attached.

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented (██████████) - 10/14/2026)

65f - Training Topics**7. Requirements**

2600.

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

Description of Violation

Staff Member A did not receive annual training in safe management techniques during training year 2025.

Staff member B did not receive training in the following topics during training year 2025:

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.

Staff Member C did not receive annual training in safe management techniques during training year 2025.

Staff Member D did not receive annual training in safe management techniques during training year 2025.

65f - Training Topics (continued)

Plan of Correction

Accept () - 10/06/2026)

On 9/24 a audit was done by (Director) for the 2026 direct care training calendar. An update was made to unsure that the required topics are being covered. This audit included reviewing all current employee training records for 2026 to ensure all current employees are up-to-date with their annual trainings. At this time all staff are up to date on their trainings and Griffith House has two scheduled staff training dates scheduled (11/6/26 and 12/11/26)

Also during that time reviewed all current employee training records for 2026. This was completed again today (10/2/26) Please note that Cross has three scheduled training session for 2026 (7/24/26) (11/6/26) and (12/11/26). As of 10/2/2026 all staff had attended the training on 7/24/26 and all staff have been informed of mandatory training days listed as 11/6/26 and 12/5/26. By attending the training on 7/24/26 all staff on currently on pace to complete all required training hours by the end of the 2026 calendar year.

The updated 2026 training calendar (attached) was completed and on 11/6/26 a new class was added to the schedule to ensure all requirements are being met for Direct Care training classes. (attached)

Also a training was completed for the leadership at Griffith on 9/23/26 by (Director) to (House Parent) and (Admin) to ensure that; moving forward, all classes will be covered on the annual training calendar. (attached)

On 10/5 a monthly audit of the staffs training calendar was started by (Director) and this will continue monthly. This is the responsibly of the House Parent () and/or (Admin) to complete monthly.

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented () - 10/14/2026)

65g - Annual Training Content

8. 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 Member B did not receive training in the following topics during training year 2025:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

65g - Annual Training Content (continued)

Plan of Correction

Accept () - 10/06/2026)

At Cross, Inc two of our homes typically do there staff training together due to the close location of the homes.
(Grace Home and Griffith House)

2025 training calendar was filed incorrectly at Grace Home in Grace Home's training file.

Attached is the training calendar showing that she completed these trainings.

On 9/24 a training was completed with the leadership at Griffith House to ensure all have the knowledge of the annual training requirements and appropriate filing. (attached) The training was given by (director) to the House Parent () and the Homes Admin ()

A audit was completed of all 2026 training calendars to ensure they are filed correctly. This was completed by (Director)

An audit of all 2025 annual trainings was completed (attached) on 10/5/26 by (director) to ensure all 2025 training sheets for all applicable staff are filed correctly.

On 10/5 a monthly audit of the staffs training calendar was started by (Director) and this will continue monthly. This is the responsibly of the House Parent () and/or (Admin) to complete monthly.

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented () - 10/14/2026)

100a - Exterior - Free of Hazards

9. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 9/1/26, at 9:51AM, the bottom of landing located outside second floor fire escape was covered in weeds, dirt, moss and overgrowth, creating slippery and hazardous conditions.

Plan of Correction

Accept () - 10/06/2026)

In the afternoon of 09/1/26; after the inspection was completed (House Parent) and (Director) cleaned and cleared the back steps that were identified during the inspection as hazardous.

On 9/23 an audit was completed by (Director) for all exit areas at Griffith House to ensure they were clean and cleared of any debris. Also training took place with the leadership at Griffith house to ensure they have the knowledge of the requirements for the safety around exterior exits. The training was given by (director) to the House Parent () and the Homes Admin ()

On 9/24 all direct care staff then were training on the same issue. The training was given by (Admin)

100a - Exterior - Free of Hazards (continued)

A monthly check is being implemented to ensure all exits are checked and cleaned monthly. (all attached) This check started on 9/23/26 and it is the responsibility of the Homes House Parent to complete this check.

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented () - 10/14/2026)

132b - Safety Inspection/Fire Drill**10. Requirements**

2600.

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

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 6/15/25.

Plan of Correction

Accept () - 10/06/2026)

On 9/4/26 a fire drill was performed by the fire department chief (attached)

On 9/23 a training was done with the leadership at Griffith House to ensure all have the required knowledge of fire drills and specifically the requirements around an annual fire drill completed by the fire dept. (attached) The training was given by () (director) to the House Parent () and the Homes Admin ()

On 9/24 a training was done with all direct care staff at Griffith House to ensure they also have the above knowledge. (attached)

On 9/24/26 a monthly fire drill audit was implemented to ensure that monthly drills are taking place and that an annual drill by the fire dept is also completed. (attached) This form is to be completed monthly by the House Parent ()

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented () - 10/14/2026)

162c - Menus Posted**11. Requirements**

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 9/1/26, the menu posted only included meals for 8/30/26, 8/31/26 and 9/1/26.

Plan of Correction

Accept () - 10/06/2026)

In the afternoon of 09/1/26; after the inspection was completed () (House Parent) reviewed the homes menu's with () (Director) and created and posted a menu for the week of 9/1/26 to 9/4/26. Also posted was a menu that covered 9/4/26 through 9/11/26. On 9/5/26 another menu was posted to cover the dates of 9/11/26 through 9/18/26 to ensure two weeks were posted.

On 9/23 a training was completed with the leadership of the Griffith House to ensure all have the knowledge of the

162c - Menus Posted (continued)

menu requirements for DHS. (attached) The training was given by [REDACTED] (director) to the House Parent ([REDACTED]) and the Homes Admin ([REDACTED])

A bi-monthly audit was implemented to ensure that the food menu is posted appropriately and covers the next two weeks. (attached) This audit is to be completed by the House Parent ([REDACTED])

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented ([REDACTED]) - 10/14/2026)

183b - Meds and Syringes Locked

12. Requirements

2600.

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

Description of Violation

On 9/1/26, at 9:30AM, the following medications were unlocked, unattended and accessible in the kitchen drawer:

- 2 tubes of Triple Antibiotic Ointment
- Preparation H
- Benadryl itch stopping gel
- Cortisone 10

All residents in the home are unable to self-administer medications.

Plan of Correction

Accept ([REDACTED]) - 10/06/2026)

In the afternoon of 09/1/26; after the inspection was completed [REDACTED] (House Parent) and [REDACTED] (Admin) cleaned and reorganized the 1st Aid drawer to ensure all required items were present and to remove the identified items that were discovered during the audit earlier in the day.

On 9/23 and 9/28 a training was completed for the homes administrator ([REDACTED]) and the homes House Parent ([REDACTED]) the training was completed by the agency Director ([REDACTED]) The training was to ensure that all have the required knowledge that OTC medication is stored appropriately. (attached)

An audit was completed of all OTC medication in the home to ensure it is stored correctly. This was completed by [REDACTED] (Director) (attached)

A monthly audit was implemented to ensure that each month all OTC meds are checked to ensure they are filed correctly. This monthly audit can be completed by either [REDACTED] (House Parent) and [REDACTED] (Admin)

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented ([REDACTED]) - 10/14/2026)

187a - Medication Record

13. Requirements

187a - Medication Record (continued)

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

8. Frequency of administration.

Description of Violation

Resident #2 is prescribed [REDACTED]. The physician orders state to take [REDACTED]. However, the resident's September 2026 Medication Administration Record (MAR) states to take [REDACTED].

Repeated Violation - 5/22/25

Plan of Correction

Accept ([REDACTED]) - 10/06/2026)

In the afternoon of 09/1/26; after the inspection was completed [REDACTED] (Admin and Med Coordinator) created a new MAR for the resident that was identified as having an incorrect MAR during the inspection.

9/23 a training was completed for the homes leadership to review the requirements on a MAR for frequency of administration. (attached) The training was given by [REDACTED] (director) to the House Parent ([REDACTED]) and the Homes Admin ([REDACTED])

9/24 an audit was completed of all MAR's in the home to ensure they matched the order completely with a focus on each residents Frequency of Administration. (Attached) This was completed by [REDACTED] (Director)

9/24 a monthly audit was implemented to check all MAR's with a focus on each residents Frequency of Administration (attached) This monthly audit can be completed by either [REDACTED] (House Parent) and [REDACTED] (Admin)

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented ([REDACTED]) - 10/14/2026)

221c - Post Activity Calendar**14. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home.

Plan of Correction

Accept ([REDACTED]) - 10/06/2026)

On 9/1/2026 after the inspection; [REDACTED] (House Parent) and [REDACTED] (Admin) created an activity calendar was created for the month of September (attached) and posted for all to see on [REDACTED]

9/23 a training was completed for the homes leadership to review the requirements of having a posted monthly activity calendar. (attached) The training was given by [REDACTED] (director) to the House Parent ([REDACTED]) and the Homes Admin ([REDACTED])

9/24 a training was completed with all staff so they as well know that a activity calendar is required monthly.

221c Post Activity Calendar (continued)

(attached) This training was given by [REDACTED] (Admin)

9/24 a monthly audit as implemented to ensure that a activity calendar is posted for each month. (Attached) This monthly audit can be completed by either [REDACTED] (House Parent) and [REDACTED] (Admin)

Oct 2026 activity calendar (attached)

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented [REDACTED] - 10/14/2026)

227a - Support Plan 30 Days**15. Requirements**

2600.

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

Description of Violation

Resident #2's was admitted to the home on [REDACTED] However, the support plan finalization dated is [REDACTED] Additionally, the managing health care section documents the name of another resident being unable to manage [REDACTED] healthcare.

Plan of Correction

Accept [REDACTED] - 10/06/2026)

The plan that was reviewed during the inspection was corrected. This was completed by [REDACTED] on 9/2/2026. The plan, on page 3, had another residents name listed on that page only. Attached is the updated page 3 with the other residents name removed.

9/23 a training was completed for the homes leadership in regards to the violation around support plans. The training was given by [REDACTED] (director) to the House Parent ([REDACTED]) and the Homes Admin ([REDACTED])

Also on 9/23 a audit was completed of all support plans to ensure no other names are listed. (attached) This was completed by [REDACTED] (Director)

9/24 Direct staff staff completed their training and a monthly audit was implemented to check each plan monthly. This monthly audit can be completed by either [REDACTED] (House Parent) and [REDACTED] (Admin)

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented [REDACTED] - 10/14/2026)

251c - Standardized Forms**16. Requirements**

2600.

251.c. The home shall use standardized forms to record information in the resident's record.

251c - Standardized Forms (continued)**Description of Violation**

The following initial and annual medical evaluations were not completed on the Department's current standardized medical evaluation form:

- *Resident #2's initial medical evaluation, dated [REDACTED]*
- *Resident #3's annual medical evaluation, dated [REDACTED]*
- *Resident #4's annual medical evaluation, dated [REDACTED]*
- *Resident #5 initial medical evaluation, dated [REDACTED]*

Plan of Correction**Accept [REDACTED] - 10/06/2026)**

On 9/2 [REDACTED] (Director) and [REDACTED] (Admin) reviewed all DME forms and due dates for all 6 residents of the home. Old DME forms were still present in the homes paper filing system and electronic filing system. These were removed and the new DME forms were put in their place to ensure that the required forms were be used moving forward. Residents #3 & #4 both have upcoming physicals this Fall; so their next physicals will be on the correct forms. The other residents do not have physicals until 2027. Moving forward all physicals will be completed on the correct forms.

On 9/23 a training was completed for the homes leadership to ensure all have the new DME form. An audit was completed to show the date of each residents last physical and how the forms were not the most current form. The training was given by [REDACTED] (director) to the House Parent [REDACTED] and the Homes Admin [REDACTED]

On 9/23 an audit was completed by [REDACTED] (director) and [REDACTED] (Admin) on all filing spaces both physical and electronic to ensure that all old and outdated forms had been deleted and replaced with the departments newest forms.

On 9/23 a monthly audit was implemented to ensure any new residents will move forward with the new medical forms. This monthly audit can be completed by either [REDACTED] (House Parent) and [REDACTED] (Admin)

Licensee's Proposed Overall Completion Date: 10/05/2026

Implemented [REDACTED] - 10/14/2026)