Department of Human Services
Bureau of Human Service Licensing

April 1, 2021

[redacted] ADMINISTRATOR
AB EAST NORRITON OPERATOR LLC
525 FELLOWSHIP ROAD, SUITE 360
MOUNT LAUREL, NJ 8054

RE: BRANDYWINE SENIOR LIVING AT
SENIOR SUITES
2101 NEW HOPE STREET
EAST NORRITON, PA, 19401
LICENSE/COC#: 14425

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/03/2021, 02/04/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *BRANDYWINE SENIOR LIVING AT SENIOR SUITES* **Licen e #**: *14425* **Licen e Expiration Date**: *05/31/2021*
Addre : *2101 NEW HOPE STREET, EAST NORRITON, PA 19401*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *6102726200* **Email**: [redacted]

Legal Entity

Name: *AB EAST NORRITON OPERATOR LLC*
Address: *525 FELLOWSHIP ROAD, SUITE 360, MOUNT LAUREL, NJ, 8054*
Phone: *6102726200* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/27/2003* **Issued By**: *L&I*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Incident* **Exit Conference Date**: *02/04/2021*

Inspection Dates and Department Representative

02/03/2021 - On-Site: [redacted]
02/04/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *245* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *40* **Residents Served**: *17*

Hospice

Current Re ident : *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *60*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

02/03/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *02/27/2021*

2/26/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/28/2021*

3/1/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/22/2021*

4/1/2021 - Document Submission

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

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 4/24/20, Staff person A took a picture of resident #2 during an incontinent care and posted the photo online to social media (Instagram) without the resident's knowledge or consent.

Plan of Correction **Do Not Accept**

The staff person in question was immediately terminated upon notification of incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents rights to be treated with dignity and respect. Residents Rights to be reviewed upon hiring and quarterly. See attachment #1

Completion Date: *03/11/2021*

Plan of Correction **Accept**

The staff person in question was immediately terminated upon notification of the incident. Executive Director ensured the post was removed from social media. All Staff will be trained on cell phone usage in the building and residents' rights to be treated with dignity and respect. Residents Rights to be reviewed upon hiring and quarterly. See attachment #1 Executive Director will ensure that all staff are trained by 3/12/2021 and will audit training records quarterly

Completion Date: *03/12/2021*

Document Submission **Implemented**

Training complete Audits scheduled

42s - Privacy

1. Requirements

2600.

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

Description of Violation

on 04/24/2020, Staff person A took a picture of resident #2 during incontinence care and posted the photo online to social media (Instagram) without the resident's knowledge or consent.

Plan of Correction **Do Not Accept**

The staff person in questions was immediately terminated upon notification of incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents rights to Privacy of self and possessions. Residents Rights to be reviewed upon hiring and quarterly. See attachment 1

Completion Date: *03/11/2021*

42s - Privacy *(continued)*

Plan of Correction **Accept**

The staff person in question was immediately terminated upon notification of the incident. Executive Director ensured the post was removed from social media. All Staff was trained on cell phone usage in the building and residents' rights to privacy of self and possessions. Residents Rights to be reviewed upon hiring and quarterly. See attachment 1

Executive Director will ensure that all staff are trained by 3/12/2021 and will audit training records quarterly.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Training complete audits scheduled

65f - Training Topics

1. Requirements

2600.

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

1. Medication self-administration training.
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.

Description of Violation

Direct care staff person B did not receive training in the above topics during training year 2019.

Plan of Correction **Do Not Accept**

Direct care staff person B is no longer direct care staff. Training plan reviewed and Direct Care Staff highlighted to ensure they have the proper annual training required including #1. Medications self-administration and #4. Infection control. Training records to be audited quarterly by Wellness Director. See attachment 2

Completion Date: *02/25/2021*

Plan of Correction **Accept**

Direct care staff person B is no longer direct care staff. Training plan reviewed and Direct Care Staff highlighted to ensure they have the proper annual training required including #1. Medications self-administration and #4. Infection control. Direct Care Training records to be audited by 3/12/2021 by Wellness Director to ensure that all required training has been completed once the initial audit is completed the Wellness Director will audit quarterly. See attachment 2

Staff member B is no longer a direct care staff member.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Records audited and quarterly audit scheduled

82c - Locking Poisonous Materials

1. 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

McKesson Fluoride toothpaste, with a manufacture's label indicating "get medical help or contact a poison control center if swallowed more than used for brushing", was unlocked, unattended, and accessible to resident #3 in the mirrored medicine cabinet in the resident's bathroom. Not all the residents of the home, including resident #3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction **Accept**

Tooth paste was removed from residents' room at the time of the inspection. Staff in-serviced on poisonous materials and proper storage. Reflections Coordinator to preform daily checks for the next month to ensure materials are properly stored then monthly checks going forward. See attachment 3

Completion Date: *03/25/2021*

Document Submission **Implemented**

Daily checks completed all materials locked monthly checks scheduled

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 02/04/2021, the bathroom in resident room [redacted] had no means of hand drying options. The paper towel dispenser was empty and no towel was available. The bath tub/shower stall in resident room [redacted] was stained with pink mold.

Plan of Correction **Do Not Accept**

During initial walk through of the building residents paper towel holder in room [redacted] was empty in the bathroom and resident's linens had not been refreshed from morning care. Resident was in the dining room having [redacted] breakfast. Housekeeping called and towels replaced prior to resident returning to her room. [redacted]s bathroom had a pink watermark on residents tub by the drain area was cleaned during inspection and housekeeping staff retrained due to hard water in the community tubs need to be monitored for hard watermarks.

Completion Date: *02/25/2021*

Plan of Correction **Accept**

During the initial walk through of the building residents, the paper towel holder in room [redacted] was empty in the bathroom and the resident s linens had not been refreshed from morning care. The resident was in the dining room having [redacted] breakfast. Housekeeping called and towels replaced prior to the resident returning to [redacted] room. [redacted] bathroom had a pink watermark on residents tub by the drain area was cleaned during inspection and housekeeping staff retrained due to hard water in the community tubs need to be monitored for hard watermarks. A daily checklist has been created to ensure compliance and will be audited weekly to verify compliance.

Completion Date *03/05/2021*

Document Submission **Implemented**

daily check lists being monitored by housekeeping supervisor

85d - Trash Receptacles

1. 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 02/04/2021 around 11:00 AM, three trash cans in the home's kitchen were not covered.

Plan of Correction **Do Not Accept**

New trash cans with lids have been purchased. Dining service director will ensure lids remain in place. See attachment 4

Completion Date: *02/25/2021*

Plan of Correction **Accept**

New trash cans with lids have been purchased. The Dining Service director will ensure lids remain in place. The Dining Service Director will train staff on sanitation and ensure that staff understands why garbage cans must be covered. Trash Receptacles will be added to daily cleaning sheets. See attachment 4

Completion Date: *03/05/2021*

Document Submission **Implemented**

Lids are in place and monitored by Dining supervisor

101i - Access to Bedroom

1. Requirements

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

On 02/03/2021 at 10:30 AM, the doors of most of the residents' rooms including room [redacted], [redacted], and [redacted] in the home's secured dementia unit (SDCU) were locked.

Plan of Correction **Accept**

All doors where unlocked during walk though. Direct care staff in serviced on residents right to have access to their bedroom at all times. Reflections Coordinator to preform daily checks for the next month to ensure doors unlocked then monthly checks going forward. See attachment 3

Completion Date: *03/25/2021*

Document Submission **Implemented**

Daily checks are complete monthly checks are scheduled

103f - Refrigerator/Freezer Temps

1. Requirements

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

Description of Violation

There was no thermometer in the ice-cream freezer in the kitchen.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction **Do Not Accept**

Thermometer added during the inspection. Dining staff trained that all refrigerators and freezers require thermometers at all times. Dining Service Director to monitor placement of thermometers. See attachment 5

Completion Date: *03/11/2021*

Plan of Correction **Accept**

Thermometer added during the inspection. Dining staff trained that all refrigerators and freezers require thermometers at all times. Dining Service Director to monitor placement of thermometers. daily for the next 30 days and then weekly after that. See attachment 5

Completion Date: *03/12/2021*

Document Submission **Implemented**

Thermometers are in place and monitored by Dining supervisor

103g - Storing Food

1. **Requirements**

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

Description of Violation

One of the round tubs of ice-cream in the home's kitchen ice-cream freezer was uncovered.
A bag of basmati rice was open and not sealed on the home's dry storage shelf.

Plan of Correction **Do Not Accept**

Lids replaced at the time of inspection and rice disposed of. Dining staff trained on the proper storage as well as proper labeling and dating of food. See attachment 5

Completion Date: *03/11/2021*

Plan of Correction **Accept**

Lids replaced at the time of inspection and rice disposed of. Dining staff trained on the proper storage as well as proper labeling and dating of food. Lids added to dining checklist. Dining Director or Dining Room Supervisor to audit daily for the next 60 days. and then weekly for the next 3 months. See attachment 5

Completion Date: *03/12/2021*

Document Submission **Implemented**

Lids are in place and monitored by Dining supervisor

183e - Storing Medications

1. **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.

183e - Storing Medications *(continued)*

Description of Violation

On 02/04/2021, there was a bottle of Timolol Maleate eye drop, prescribed for resident #4, with an open date of 12/11/2020 in the home's 2nd floor med cart. According to the manufacturer's instructions, the eye drop should be thrown away 28 days after opening.

Plan of Correction **Do Not Accept**

Eye drops disposed of at time of inspection, new bottle in the cart. Nursing staff will be retrained on proper storage procedures. All medication will be dated and disposed of according to manufactures guidelines. Reference sheet will be created to address when medications should be discarded after opening. See attachment 6

Completion Date: *03/11/2021*

Plan of Correction **Accept**

Eye drops disposed of at the time of inspection, a new bottle in the cart. Nursing staff will be retrained on proper storage procedures. All medication will be dated and disposed of according to manufacturers' guidelines. A reference sheet will be created to address when medications should be discarded after opening. The cart will be audited weekly on the 11-7 sheet and the audit sheet will be reviewed by the Wellness DirectorSee attachment 6

Completion Date: *03/12/2021*

Document Submission **Implemented**

nitial month of weekly audits completed by Wellness Director. On going weekly checks are being done by 11-7 and monitored by wellness director.

184a - Labeling OTC/CAM

1. **Requirements**

2600.

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 #5's Tramadol 50 mg says 4 times daily as needed but the order changed to once daily at 09:00 PM. A direction change sticker was not present on the card.

Plan of Correction **Do Not Accept**

Nursing staff will be retrained on proper labeling of medications due to direction change by doctor and the use of direction change stickers. See attachment 6

Completion Date: *03/11/2021*

184a - Labeling OTC/CAM *(continued)*

Plan of Correction **Accept**

Nursing staff will be retrained on proper labeling of medications due to direction change by the doctor and the use of direction change stickers. Carts to be audited weekly by the 11-7 nurse and audit sheet reviewed by the Wellness Director weekly See attachment 6

Completion Date: *03/12/2021*

Document Submission **Implemented**

nitial month of weekly audits completed by Wellness Director. On going weekly checks are being done by 11-7 and monitored by wellness director.

185b - Medication Procedures

1. **Requirements**

2600.
185.b. At a minimum, the procedures must include:

Description of Violation

On 02/04/2021 at 09:18 AM, resident #6 was given [redacted] daily dose of Lorazepam Intensol 2 mg. This medication was not signed out on the resident's Controlled Substance Record.

The Controlled Substance Record for resident #7's Oxycodone 10 mg showed a remaining quantity of 48. The actual number of pills available at the time of the inspection was 47. The home was unable to explain the discrepancy.

Plan of Correction **Do Not Accept**

Nursing staff coached and retrained on proper medication procedures. See attachment 6

Completion Date: *03/11/2021*

185b - Medication Procedures *(continued)*

Plan of Correction **Directed**

Nursing staff coached and retrained on proper medication procedures. MAR to be audited by the Wellness Director on a monthly basis for the next 6 months and then randomly thereafter. See attachment 6
Licensee's Proposed Date for POC Implementation: 3/12/2021

Directed 3/1/2021 CM: Immediately, a narcotic count will be conducted by two staff persons daily on each shift. Documentation will be kept.

Within 30 days of receipt of the plan of correction: The administrator will review and update if necessary the home's procedures for the safe storage, access, security, distribution and use of medications, including the procedures for medication accountability. All staff persons qualified to administer medications will be reeducated on the home's policy and procedures. Documentation of education shall be kept.

The administrator will conduct a check of the home at least weekly to ensure the proper storage of medications ncluding syringes.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Policy review with all LPN giving medications. We do not have med techs in this community. Weekly checks in place.

187a - Medication Record

1. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident #8 is prescribed Novolog insulin injection on a sliding scale: 200-250 requires 4 units, 251-300 6 units, 301-350 8 units, and 351-400 10 units. However, the resident's Jan 2021 medication administration record (MAR) does not indicate the units of insulin given.

Plan of Correction **Do Not Accept**

EMAR adjusted to ask for the amount of insulin given See attachment 9
Completion Date: *02/25/2021*

187a - Medication Record *(continued)*

Plan of Correction **Directed**

EMAR adjusted to ask for the amount of insulin given. Wellness director will observe compliance on monthly EMAR audit. Wellness Director will ensure all parameters for medications are documented upon admission and monthly See attachment 9
Licensee's Proposed Date for POC Implementation: 3/12/2021

Directed 3/1/2021 CM: Within 30 days of the receipt of the accepted plan of correction, all staff persons qualified to administer medications will be re-educated, by a certified medication administration Train-the-Trainer, on the required documentation of MARs in accordance with regulation 2600.187(a) including the proper documentation of prescription orders, medication dosage, and a purpose or diagnosis for each medication. Documentation of education shall be kept in the staff records.
A designated staff person qualified to administer medications will review all resident MARs and prescription orders at east weekly for the first three months, then monthly thereafter, to ensure all prescribed medications are documented on the MARs including the medication dose and the purpose or diagnosis for each medication. Documentations of reviews will be kept.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Policy and regulations review with all LPN giving medications. We do not have med techs in this community. Weekly checks in place.

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #7 is prescribed Oxycodone 10 mg - take 1 tablet by mouth every 6 hours as needed - was signed out almost daily at 06:00 AM according to its sign-out sheet. The resident's Jan 2021 MAR does not include the initials of the staff person who administered it on 01/01, 02, 04, 05, 06, 07, 08, 12, 13, 14, 16, 20, 21, 22, 23, 25, 26, 27, and 28/2021. Resident #9 is prescribed Morphine Sul 100/5 ml every 3 hours as needed. The resident's January 2021 MAR does not include the initials of the staff person who administered it on 01/05, 01/12 and 01/27/2021.

Plan of Correction **Do Not Accept**

Policy reviewed with all nursing staff on proper medication procedures. Nursing staff on duty during the days in question coached and counseled. See attachment 6

Completion Date: *03/11/2021*

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

Plan of Correction **Directed**

Policy reviewed with all nursing staff on proper medication procedures. Nursing staff on duty during the days in question coached and counseled. Wellness director will observe compliance on monthly EMAR audit. See attachment 6

icensee's Proposed Date for POC Implementation: 3/12/2021

Directed 3/1/2021 CM: Immediately The administrator or designee qualified to administer medications will complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b).

mmediately: A designated staff person qualified to administer medications will review all resident MARs at least weekly to ensure the proper documentation of medication administration at the time of administration. Documentation of reviews will be kept.

Within 30 days of receipt of the accepted plan of correction: All staff persons qualified to administer medications will be re educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept.

Completion Date *03/12/2021*

Document Submission **Implemented**

Policy and regulations review with all LPN giving medications. We do not have med techs in this community. Wellness Director audited all carts to ensure all medications are available Weekly checks in place.

201 - Positive Interventions

1. **Requirements**

2600.

201. Safe Management Techniques The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

On 02/29~03/01/2020 during the night shift, resident #1 wandered the hallways, screaming, yelling, and banging on other residents' doors. The staff on duty failed to implement positive interventions to redirect or de-escalate the situation, and at one point, the resident started wielding a metal rod in front of the care manager. The resident was found with bruises and wounds on [redacted] left arm next day.

Plan of Correction **Do Not Accept**

Staff in serviced and trained on positive interventions and de-escalation techniques. Care manager in question was suspended immediately and was later terminated. See attachment 7

Completion Date: *03/11/2021*

201 - Positive Interventions *(continued)*

Plan of Correction **Directed**

Staff in serviced and trained on positive interventions and de-escalation techniques. Care manager in question was suspended immediately and was later terminated. Staff will receive de-escalation by the wellness director upon hire and as needed when behaviors are noted. See attachment 7
Licensee's Proposed Date for POC Implementation: 3/12/2021

Directed 3/1/2021 CM: Immediately: The administrator or designee will monitor the care and services of for residents whom require mental health or behavioral care and services for at least two residents a week for three months and biannually thereafter to ensure the residents are receiving the care and services indicated in the resident's support plans and the use of positive interventions is implemented. Documentation of monitoring shall be kept.

Completion Date: *03/12/2021*

Document Submission **Implemented**

Wellness Director reviewing the care and services for residents whom require mental or behavioral health as directed

224a - Preadmission Screen Form

1. **Requirements**

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #10's preadmission screening form, dated 11/22/2020, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction **Do Not Accept**

Screening repaired at the time of inspection. Going forward admission paperwork with be screened by a second person.

Completion Date: *02/25/2021*

Plan of Correction **Accept**

Screening repaired at the time of inspection. Going forward admission paperwork with be screened by a second person. As of2/26/2021 all records have been audited by the wellness director for compliance. Wellness Director and Executive Director will audit all new admission charts for compliance on going.

Completion Date: *02/26/2021*

Document Submission **Implemented**

Admission documents review by WD and ED

225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

225c - Additional Assessment *(continued)*

Description of Repeat Violation

Resident #1's most recent assessment was completed on 04/14/2020. However, the condition of the resident changed significantly around November 2019, when the resident developed behavioral issues including aggressive episodes.

Repeated Violation: 8/26/2020

Plan of Correction **Do Not Accept**

Nursing staff has been educated and in serviced on updating the RASP as incidents occur. All remaining resident's charts have also been audited for updating and a compliance tickler is being utilized for regular monitoring and compliance. Resident in question was evaluated and assessed as needing a higher level of care and was moved into the secured memory care neighborhood. See attachment 8

Completion Date: *03/11/2021*

Plan of Correction **Accept**

Nursing staff has been educated and in serviced on updating the RASP as incidents occur. All remaining resident's charts have also been audited for updating and a compliance tickler is being utilized for regular monitoring and compliance. Resident in question was evaluated and assessed as needing a higher level of care and was moved into the secured memory care neighborhood. Per the attachment records will be monitored monthly for changes in condition. See attachment 8

Completion Date: *02/26/2021*

Document Submission **Implemented**

Tickler in place

251b - Record Entries Legible

1. **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

On the Controlled Substance Record for resident #7's Oxycodone 10mg, all fields of the 2nd line of entry are scratched out without proper notation. On the entry for 1/9/21, part of the date and the amount on hand are written over, and the amount received and the amount given are crossed off without proper notation. On the entry just below, labeled as 11/10/21, the amount received field is crossed out without proper notation.

Plan of Correction **Do Not Accept**

Staff trained on the importance of writing legibly. See attachment 6

Completion Date: *03/11/2021*

251b - Record Entries Legible *(continued)*

Plan of Correction **Accept**

Staff trained on the importance of writing legibly. written records will be monitored by the wellness director weekly for the next 3 months than monthly going forward for compliance. See attachment 6

Completion Date: *03/12/2021*

Document Submission **Implemented**

Written records monitored weekly for legibility