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

October 1, 2025

[redacted], ADMINISTRATOR
BFG POCONO SPRINGING, LLC
[redacted]

RE: SPRING VILLAGE AT POCONO
329 EAST BROWN STREET
EAST STROUDSBURG, PA, 19301
LICENSE/COC#: 23293

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/12/2025, 08/18/2025 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]or

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SPRING VILLAGE AT POCONO* **License #**: *23293* **License Expiration**: *04/21/2026*

Address: *329 EAST BROWN STREET, EAST STROUDSBURG, PA 19301*

County: *MONROE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *BFG POCONO SPRINGING, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/01/2013* **Issued By**: *E Stroudsburg Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *143* **Waking Staff**: *107*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *08/18/2025*

Inspection Dates and Department Representative

08/12/2025 - On-Site: [redacted]

08/18/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *105* **Residents Served**: *87*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *secured* **Capacity**: *40* **Residents Served**: *39*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *87*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *56* **Have Physical Disability**: *7*

Inspections / Reviews

08/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/07/2025*

09/09/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/16/2025*

Inspections / Reviews *(continued)*

09/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/25/2025*

10/01/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2025*

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

At approximately 9:25 a.m., a resident treatment sheet was left out on a table in the Delaware Water Gap room. A resident refill order form was left out and unattended on top of a medication cart located in front of the elevator doors. At approximately 9:40 a.m., a paper listing resident names and toileting and mobility needs was found on a cart in the hallway of the secure dementia unit. A blue binder with resident mobility needs was found in the Delaware Gap common area.

Plan of Correction ***Accept ([redacted] - 09/16/2025)***

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.

On 8/13/2025 all binders were removed from the floor and locked in a closet that care managers and medication tech have access to with a key. The were moved by the Personal Care Coordination.

On 8/27/25 and 8/28/25, Executive Director, held an in-service with Care Managers and Medication technicians to discuss regulation 2600.17.

On 9/09/25 all care managers and med techs signed an additional in-service discussing that all paperwork involving resident names and care schedules may not be left out and must be kept on their person or locked in the closet.

SVP will be moving to a computerized ADL tracking and documentation system called ALIS. Paper treatment sheets will no longer be used. Care managers will document on computerized tablets that they always keep on their person.

Executive Director will be responsible for maintaining compliance by training Care Managers on ALIS system and surveying the floor daily to make sure treatment sheets are not left out.

See attachments

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

25b - Contract Signatures

2. Requirements

2600.

25b - Contract Signatures *(continued)*

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 was not dated or signed by resident # 2.
The resident home contract dated 7/15/25 for resident # 3 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 09/16/2025)***

All contracts should 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.

The contract was not signed by resident #2 or resident #3 as they resides in our secured Memory Care unit and were not able to sign.

On August 13,2005 the Executive Director spoke with Director of Community Relations (DCR), about correct contract practices. DCR was informed that all residents need to be presented the opportunity to sign the contract and that the POA was only to be used if the resident was unable to sign. If resident is unable to sign due to inability or dementia, it needs to be documented. On August 13,2025 the contracts were presented to resident #2 and #3. They were stamped with inability to sign due to dementia stamps due to inability to sign.

The DCR will be responsible for obtaining all signatures and dates from residents and POA on contracts.

In addition the DCR will be responsible for auditing contracts for signatures and dates. Audits will begin on September 15,2025 and continue quarterly. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.

See attachments

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented ([redacted] - 10/01/2025)

25c2 - Fee Schedule

3. Requirements

2600.
25.c. At a minimum, the contract must specify the following:

Description of Violation

The home charges specified amounts for individual personal need services. The Attachment B, Schedule of resident Fees sheet for resident # 2 does not include actual amounts charged for services.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

At a minimum the contract must specify the home charges specified amounts for individual personal need services.

On August 13, 2025 the Director of Community Relations audited resident #2 chart and found that the fees were missing. The DCR immediately updated the chart.

25c2 - Fee Schedule (continued)

The DCR will audit all contracts. Audits will begin on September 15,2025 and continue quarterly . This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.

See attachments

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented (- 10/01/2025)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed (- 09/17/2025)***

Direct care staff persons shall have the following qualifications: a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Direct Care Staff A's High School Diploma was missing from chart. The Executive Director contacted Direct Staff A, who was able to get a copy sent to Direct Care Staff A submitted diploma to ED on 8/14/2025.

An Audit of all Direct Care Staff was completed on 8/22/25. In addition the ED will audit all charts for required documents upon hiring, if documents are missing staff will not be able to work on the floor.

This will be discussed at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.

See attachments

Proposed Overall Completion Date: 09/10/2025

Directed: In addition to the above plan of correction, Direct Care Staff A will be removed from performing direct care duties until a waiver is applied for and approved due to the high school diploma being from a non-US secondary school.

Directed Completion Date: *09/18/2025*

Implemented (- 10/01/2025)

82c - Locking Poisonous Materials

5. 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

At approximately 9:28 a.m., the door to the beauty shop in the secure dementia unit was unlocked. A bottle of eyewash with a manufacture's label indicating "call poison control if swallowed" was unlocked, unattended, and accessible to residents. Bottles of Lime away and bleach with manufacture's labels indicating "harmful if swallowed" were unlocked, unattended, and accessible to residents in the unlocked bathroom closet of the beauty shop.

Repeat Violation: 3/4/25.

Plan of Correction ***Accept (- 09/17/2025)***

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.

The salon door was left unlocked on the third floor risking access to hazardous materials. On 8/14/2025 Director of Maintenance replaced the lock on the Beauty Salon; keys were given to care managers and maintenance.

In addition, a sign has been posted to keep door closed and locked.

Director of Maintenance and ED will monitor daily for compliance.

Training on regulation 2600.82 c was completed with Direct Care Staff and Medication Techs on 8/27/25 and 8/28/25. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/10/2025*

Implemented (- 10/01/2025)

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

At 9:55 a.m., there was a full, uncovered, unattended trash can in the in the employee's 2nd floor bathroom.

Plan of Correction ***Accept (- 09/17/2025)***

Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

The lid in the staff bathroom was broken. The Director of Maintenance fixed lid on 8/12/25

A new trash can with working lid was installed in bathroom on 8/14/2025 by Director of Maintenance.

85d - Trash Receptacles (continued)

In addition this was discussed at direct care staff in service on 8/27 & 8/28.

Housekeeping will monitor for compliance by conducting daily checks of garbage cans. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/10/2025*

Implemented ([redacted] - 10/01/2025)

101o - Walls, Floors, Ceilings

7. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

At 9:52 a.m., resident #4's bedroom had a cord extended from the bed to a wall outlet located next to their bedside table, creating a tripping hazard.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Upon inspection resident #4's bedroom had a cord extended from the bed to a wall outlet located next to their bedside table, creating a tripping hazard. The Director Of Maintenance rearranged the furniture to allow for the cord to lay more closely against the wall on 8/13/25.

In addition this was discussed at the direct care training on 8/27/25 & 8/28/25, the purpose was to empower all staff that if they see a tripping hazard they are responsible to help eliminated it.

Director of Maintenance will monitor for compliance by conducting monthly checks on the 15th of every month. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

102i - Soap Dispenser

8. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At approximately 2:58 p.m., there was an unlabeled used bar of soap found in resident #5 and resident # 6's shared bathroom.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there

102i - Soap Dispenser (continued)

is a separate bar clearly labeled for each resident who shares a bathroom.

Bar of unlabeled soap in resident #5 and #6 room was discarded by Executive Director on 8/12/25.

Executive Director will work with DCR to make sure that all shared room hygiene goods are labeled upon admission and before they are placed in the residents room.

Upon admission families will be educated that all items need to be labeled.

Staff members were educated on reg 2600.102i on 8/27/25 & 8/28/25 during in service.

Maintenance Director will audit Secured Memory Care rooms the 15th of every month for compliance. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/15/2025*

Implemented ([redacted] - 10/01/2025)

131f - Fire Extinguisher Inspection

9. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the facility transport van had a tag with an expiration date of October 2024.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

The fire extinguisher in the transport van was missed for monthly inspection and it's expiration date had been reached. Director of Maintenance immediately switched out the expired fire extinguisher on 8/12/2025.

In addition all fire extinguishers in the building will be inspected and replaced if needed by a fire safety expert by October 31, 2025.

Director of Maintenance will monitor for compliance by conducting monthly checks of all fire extinguishers on the 15th of the month and signing the backs of the tags. This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/10/2025*

Implemented ([redacted] - 10/01/2025)

141a - Medical Evaluation

10. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The initial medical evaluation dated [redacted] for resident # 2 was missing page 4 and did not include a list of the resident's medications.
The initial medical evaluation dated [redacted] for resident # 7 did not include the resident's height or the medical license number of the medical professional who signed the form.
The medical evaluation dated [redacted] for resident # 8 did not include a list of the resident's medications.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

The DON and nursing staff worked to update the missing information as noted: Resident #2 was missing medication list, Resident #7 was missing height and medical license number, Resident #8 was missing medication list. All items were obtained by the nursing department and updated resident charts by 8/22/25 .

Inservice was done with nursing department on 9/4/25 on regulation 2600.141.

Going forward medical charts will be audited monthly by a nurse for compliance. Audits will be held by the third Tuesday of every month. The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/10/2025*

Implemented ([redacted] - 10/01/2025)

141b1 - Annual Medical Evaluation

11. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 12's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]
Resident # 9's most recent medical evaluation was completed on [redacted]. The resident's medical evaluation did not include the name of the medical professional.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

A resident shall have a medical evaluation: At least annually.

Re-Education on regulation and timelines for DME's was done with nursing department on 9/3/2025.

141b1 - Annual Medical Evaluation (continued)

Resident #9 DME has been corrected to include the name of the medical professional that completed it on 8/22/25.

Going forward medical charts will be audited monthly by a nurse for compliance by the third Tuesday of every month. The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/10/2025*

Implemented ([redacted] - 10/01/2025)

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

At 2:10p.m., Ketoconazole 2% shampoo was unlocked, unattended, and accessible in Resident #15's bathroom.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

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.

Re-education on medication regulation2600.183b was done at an in-service for med-techs on 8/27/25 and 8/28/25.

In addition the medicated shampoo that belonged to resident # 15 was removed from the room on 8/12/25 and returned to the med cart.

Resident #15 was educated on 8/13/25 as to why [redacted] could not have the medicated shampoo in [redacted] room at all times.

Nursing will monitor for compliance by conducting a monthly cart audit by the third Friday of every month. The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

183e - Storing Medications

13. 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

Open Lantus insulin pens were being stored in the refrigerator. According to the manufacturer's instructions insulin pens are to be stored in the refrigerator until opened. Once opened, they are to be stored at room temperature.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

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.

Re-education was done at a Med-Tech in service on 8/27/25 & 8/28/25. In addition opened Lantus pens were removed from the refrigerator on 8/12/25 and placed in the cart.

Nursing will monitor for compliance by conducting a monthly cart audit by the third Friday of every month. The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1's Bisacodyl suppository does not have a pharmacy label. The suppository was in a clear plastic bag.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

The correct label was obtained by pharmacy on 8/13/25.

Medication Techs were re-educated on 8/27/25 & 8/28/25.

Nursing will monitor for compliance by conducting a monthly cart audit by the third Friday of every month.

184a - Resident's Meds Labeled (continued)

The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.

See attachments

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

184b - Labeling OTC/CAM

15. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

At approximately 9:40 a.m., a care bag was found on a cart in the hallway outside of resident room 333. The bag contained tubes of Zinc Oxide 20%, Zinc oxide 40%, and Thera Calazine body shield. The over-the-counter creams were not labeled with the resident name.

Plan of Correction ***Accept ([redacted] - 09/17/2025)***

If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

All OTC medications have been removed from Care Manager Bags by Personal Care Coordinator on 9/09/25.

Only creams labeled with residents names are to be used once obtained from Med Tech.

The use of Care Manager Bags will be eliminated from the floor by 9/15/25.

Personal Care Coordinator will monitor for compliance daily when checking to make sure care bags are not being used.

This will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.

Licensee's Proposed Overall Completion Date: *09/16/2025*

Implemented ([redacted] - 10/01/2025)

185a - Implement Storage Procedures

16. 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

At 2:29 p.m., resident # 10's, Lorazepam 0.5 mg tablet medication card, pill #60 was opened and resealed with clear tape on the back to keep the pill in place. Resident # 10's Oxycodone HCL 5 MG tab medication card, pills #25, # 38, #46 was opened and resealed with clear tape on the back to keep the pills in place. Resident # 13's Lorazepam 0.5 MG tablet medication card, pills #11, #13, #14, # 15, #19, # 21, # 22, # 28 were opened and resealed with clear tape on

185a - Implement Storage Procedures (continued)

the back to keep the pill in place.

Resident # 14's PRN medication Baqsimi 3 MG spray Two Pack was not on the medication cart and not available in the home.

Plan of Correction ***Accept (- 09/17/2025)***

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.

Staff have been instructed that pills should never be pre-popped. If a pill backing is damaged, it needs to be used or wasted/ if a narcotic it should be wasted by 2 people. Resident #10 Lorazepam & Oxycodone ,and Resident #13 Lorazepam popped and taped pills were wasted by 2 nurses.

Re-education with Med-Techs took place on 8/27/25 & 8/28/25.

Resident #14 PRN medication was reordered on 8/12/25.

Nursing will monitor for compliance by conducting a monthly cart audit by the third Friday of every month.

The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/19/2025*

Implemented (- 10/01/2025)

231c - Preadmission Screening

17. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident # 3 was admitted to the home's secure dementia unit on . The cognitive screening form did not include the date the form was completed and did not include the name of the person who completed the form.

Plan of Correction ***Accept (- 09/17/2025)***

A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Resident #3 cog screen was missing date and transcriber information. Form was presented to original transcriber to fill in missed information and completed on 8/22/25.

An Inservice on reg 231C is scheduled for 9/18/25. ED will conduct in service and have all nurses sign

231c - Preadmission Screening (continued)

Going forward nursing will audit all charts at time of admission for missing information. The audit will be discussed and checked at our monthly QA meetings by the ED, QA meeting held last Thursday of the Month.
See attachments

Licensee's Proposed Overall Completion Date: *09/18/2025*

Implemented ([redacted] - 10/01/2025)