STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING -- B. WING	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/06/22 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Emergency Preparedness survey, Munster Med-Inn, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 225 certified beds. At the time of the survey, the census was 177. Quality Review completed on 12/07/22	E 0000	The facility kindly requests a desk review	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/06/22 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Life Safety Code survey, Munster Med-Inn was found not in compliance with	K 0000	The facility kindly requests a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Petty	Administrator	12/13/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This six-story facility with a full basement was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery operated smoke detectors are installed in all resident rooms. The building is fully protected by a 200-kW diesel-powered generator. The facility has the capacity for 225 and had a census of 177 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/07/22			
K 0300 SS=E Bldg. 03	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace 2 of over 100 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published	K 0300	**Munster Med Inn** **Life Safety Code** **Recertification and State** **Licensure Survey: 12-6-2022** K 300 Please accept the following as the	12/13/2022

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	instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 30 residents, staff, and visitors in the vicinity of resident rooms 108 & 216 . Findings include: Based on observations with the Maintenance Director and Corporate Facilities Engineer on 12/06/22 during a tour of the facility from 9:50 a.m. to 12:25 p.m., manufacturer's documentation affixed to the battery operated smoke alarms installed on the ceiling in resident sleeping rooms 108 & 216 indicated each device was manufactured 07/26/2011 and 05/25/2011 respectively. Based on interview at the time of each observation, the Maintenance Director agreed the aforementioned smoke alarms were more than ten years old. These findings were reviewed with the Maintenance Director and Corporate Facilities Engineer during the exit conference. 3.1-19(b)		facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *resident rooms 108 and 216 battery operated smoke detectors had a service life of ten years and needed replaced. Room 108 and 216 smoke detectors have been replaced and working properly.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect residents in rooms108 and 216 if the smoke detector were to fail during a fire* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was re-educated on the life span of a battery operated smoke detectors. All battery operated smoke detectors over ten years old have replaced to ensure compliance.*	

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			How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Smoke detector replacement requirements will be reviewed at the safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 12/13/2022**	
K 0345 SS=C Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 12-6-2022** K 345 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is	12/13/2022

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	Based on observations with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility from 9:50 a.m. to 12:25 p.m. on 12/06/22, the date and the time of day for the main fire alarm control panel were incorrect. The display read the date as February 13, 2006 and the time of day as 2:13 a.m. at 11:30 a.m. Based on interview at the time of the observations, the Corporate Facilities Engineer agreed the main fire alarm control panel did not display the correct date and the correct time of day. This finding was reviewed with the Maintenance Director and Corporate Facilities Engineer during the exit conference. 3.1-19(b)		submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *A call was place to Koorsen fire alarm to make repairs/correction to reset panel. Panel now showing correct time and date.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all residents, staff and visitors. The panel is fully functional and now displays the correct date* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was re-educated to inspect panel for correct information. A weekly random audit will be conducted for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will*	

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			be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence. **Date of Completion: 12/13/2022**	
K 0355 SS=D Bldg. 03	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the generator room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators.	K 0355	**Munster Med Inn** **Life Safety Code** **Recertification and State Licensure Survey: 12-6-2022** K 355 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *Fire extinguisher in generator room had not had a monthly inspection. All fire extinguishers require a monthly*	12/13/2022

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	Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the vicinity of the generator room. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Corporate Facilities Engineer on 12/06/22 at 11:41 a.m., the monthly inspection tag on the ABC fire extinguisher located in the generator room was missing documented inspection for October and November 2022. Annual fire extinguisher testing was performed 09/12/2022 by the contracted vendor. Based on interview at the time of observation, the Maintenance Director confirmed the extinguisher located in the generator room was missing two months of documented inspections. This finding was discussed with the Maintenance Director and Corporate Facilities Engineer at exit conference. 3.1-19(b)		*inspection All fire extinguishers have been inspected.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff in the vicinity of the generator room if the fire extinguisher were to fail during a fire* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on checking the fire extinguishers monthly. A weekly random audit will be conducted for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 12/13/2022**	

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K 0363 SS=D Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 100 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observation with the Maintenance Director and Corporate Facilities Engineer on 12/06/22 during a tour of the facility at 11:08 a.m., the corridor door to resident room 210 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not latch into the door frame, and would work on the door so it would latch. This finding was reviewed with the Maintenance Director and Corporate Facilities Engineer at the exit conference. 3.1-19(b)	K 0363	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 12-6-2022** K 363 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *Resident room door 210 did not latch when closed. Door was adjusted and tested. Door now latching properly.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect resident in room 210 if door did not latch during a fire.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on the need for doors to latch properly. A*	12/13/2022

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			weekly random audit of doors will be conducted for 3 months to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 12/13/2022**	
K 0374 SS=E Bldg. 03	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility	K 0374	**Munster Med Inn**	12/13/2022

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	failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors, and an undetermined number of residents going through the main entrance and Administration Hall. Findings include: During a tour of the facility with the Maintenance Director and Corporate Facilities Engineer on 12/06/22 at 11:59 a.m. the set of smoke barrier doors near the Administration Office did not fully close due to a malfunctioning coordinator. The doors remained approximately 6 inches apart when closed. Based on interview at the time of observation, the Maintenance Director and the Corporate Facilities Engineer agreed that the doors did not fully close. This finding was reviewed with the Maintenance Director and Corporate Facilities Engineer at the exit conference. 3.1-19(b)		**Life Safety Code Recertification and State Licensure Survey: 12-6-2022** K 374 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The coordinator on fire/smoke doors hallway by front Administration offices has been adjusted and tested. Doors are now closing and latching properly.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors on the ground floor if doors did not close and latch during a fire.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on use of coordinators on fire and smoke doors and need for doors to close*	

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			and latch properly. A weekly random audit of all fire/smoke doors with coordinators for 3 months will be conducted to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 12/13/2022**	
K 0741 SS=E Bldg. 03	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are			

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	prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to enforce its own Smoking Policy. This deficient practice could affect as many as two employees who were observed smoking outside the facility near the facility 200 kW generator. Findings include: Based on observation with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility at 11:43 a.m. on 12/06/22, over ten cigarette butts were strewn on the ground outside the back dock near the facility 200 kW generator. Furthermore, a female facility employee was sitting on a chair on the dock smoking a cigarette. Next to where the employee was sitting was a 12 gallon plastic container that had discarded cigarette butts and trash inside. There was a smouldering cigarette butt in the container with the trash. When asked if that location was a designated smoking area, the Corporate Facilities Engineer stated that Munster Med-Inn was a non-smoking facility and employees are to smoke in their vehicles. The Maintenance Director	K 0741	**Munster Med Inn** **Life Safety Code** **Recertification and State Licensure Survey: 12-6-2022** K 741 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *Employee was outside smoking and disposed a cigarette in a non-approved can. The facility is non-smoking. Staff have been Re-educated on facility non-smoking policy. The plastic butt container has been removed.*	12/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 03 B. WING	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

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	poured water inside the plastic container to distinguish the smouldering cigarette and the plastic container was removed away from the facility. This finding was reviewed with the Maintenance Director and the Corporate Facilities Engineer at the exit conference. 3.1-19(b)		**How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all resident and staff areas near where the employee was smoking.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Staff have been re-educated on the facility non-smoking policy. A weekly random audit will be conducted for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 12/13/2022**	

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K 0920 SS=B Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords and power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety	K 0920	**Munster Med Inn** **Life Safety Code** **Recertification and State Licensure Survey: 12-6-2022** K 920 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	12/13/2022

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	shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect staff in the vicinity of the Business Office and Laundry. Findings include: Based on observations with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility from 9:50 a.m. to 12:25 p.m. on 12/06/22, the following was noted: a) a refrigerator was plugged into a power strip in the laundry room located in the basement b) a coffee pot was plugged into an extension cord in the Business Office. Based on interview at the time of the observations, the Maintenance Director agreed a power strip and an extension cord were being used as substitutes for fixed wiring at the aforementioned locations. The power strip and extension cord were removed at the time of observations by the Maintenance Director. This finding was reviewed with the Maintenance Director and Corporate Facilties Engineer during the exit conference. 3.1-19(b)		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The extension cord and power strip were immediately removed from the laundry room and the business office.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all resident, staff and visitor areas near the office's where the extension cord and power strip were in use* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance director re-educated office staff on not using extension cords and power strips in the facility. A weekly random audit of offices will be conducted for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3*	

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			months. All other deficient practices will be immediately corrected upon occurrence. **Date of Completion: 12/13/2022**	