STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD, GREENWOOD, , 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes IN00464663, IN00464732, IN00464788, and IN00464821. Intake IN00464663 - No deficiencies related to the allegations are cited. Intake IN00464732 - No deficiencies related to the allegations are cited. Intake IN00464788 - No deficiencies related to the allegations are cited. Intake IN00464821 - State deficiencies related to the allegations are cited at R241 and R349. Unrelated deficiency is cited Survey date: September 16 and 17, 2025 Facility number: 014079 Residential Census: 72	R 0000	**This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.** **Submission of this Plan is evidence of compliance.**	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 19, 2025.			
R 0089	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(e)(1-2)(f) (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on observation and interview, the facility failed to ensure an Administrator was employed to work in the facility. Finding includes: During an interview on 9/16/25 at 8:47 a.m., Qualified Medication Aide (QMA) 1 indicated the facility did not have an Administrator. An Administrator from a sister	R 0089	**1** **Corrective action for affected resident(s):** Residential Care Administrator was hired 9/29/2025 and change form was submitted to ISDH. Receipt of change form was confirmed by ISDH on 9/30/2025. **2. Identification of other residents potentially affected:** All residents had the potential to be affected due to the absence of a licensed administrator employed full time at this community. With the absence of a licensed administrator at this community, the community's parent company had arranged for frequent onsite and consistent remote coverage/ support by two additional licensed administrators within the company. This plan was submitted to ISDH for consideration upon termination of the community's previous Executive Director by the community's Vice	09/29/2025

	facility had been filling in. During an interview on 9/17/25 at 9:24 a.m., the Director of Nursing (DON) indicated a new full time Administrator had been hired and another Administrator had been filling in until the new Administrator started. An Administrator had not been observed in the facility during the survey from 9/16/25 at 8:10 a.m. until 9/17/25 at 1:00 p.m. On 9/17/25 at 1:00 p.m., the facility was unable to provide a policy by survey exit. Based on observation and interview, the facility failed to ensure an Administrator was employed to work in the facility. Finding includes: During an interview on 9/16/25 at 8:47 a.m., Qualified Medication Aide (QMA) 1 indicated the facility did not have an Administrator. An Administrator from a sister facility had been filling in. During an interview on 9/17/25 at 9:24 a.m., the Director of Nursing (DON) indicated a new full time Administrator had been hired and another Administrator had been filling in until the new Administrator started. An Administrator had not been observed in the facility during		President of Operations. The hiring and onboarding of a licensed administrator ensures that the community and its residents are now under appropriate administrative oversight and compliance management. **3. Systemic changes to prevent recurrence:** The community's leadership shall ensure that a dedicated interim administrator or acting designee be appointed within 48 hours should the administrator position become vacant. **4. Monitoring / Quality Assurance plan:** Community leadership shall review administrator licensure status at least annually, and verify that the administrator of record remains active and in good standing with the Indiana State Department of Health. This verification shall be maintained within the administrator's personnel record. **5. Completion date: September 29, 2025** – Deficiency corrected with the hiring and	

	the survey from 9/16/25 at 8:10 a.m. until 9/17/25 at 1:00 p.m. On 9/17/25 at 1:00 p.m., the facility was unable to provide a policy by survey exit.		onboarding of a licensed administrator.	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure insulin was administered by insulin certified nursing staff for 2 of 3 residents reviewed for insulin administration. Two residents with physician's orders to have qualified nursing staff to administer insulin were asked to administer their own insulin injections by two Qualified Medication Aides (QMA) that were not certified to administer insulin. (Resident B, Resident C) Findings include: 1. During an interview on	R 0241	**1. Corrective action for affected resident(s):** The resident(s) identified in the citation are now receiving insulin in accordance with the physician’s order. Medication administration for these residents has been transitioned to licensed nursing staff to ensure compliance with state regulation and physician directives. **2. Identification of other residents potentially affected:** The Director of Health and Wellness completed audit of current community residents who receive medications that require skilled administration (including insulin, injections, and PRN medications). **3. Systemic changes to prevent recurrence:** Daily staffing assignments have been adjusted to ensure the presence of a **Licensed Practical Nurse (LPN)** and/or **insulin-certified QMA** on each shift when insulin administration is	11/30/2025

	9/16/25 at 9:29 a.m., Resident B indicated, on 9/13/25 at lunch time, QMA 2 entered her apartment with an insulin syringe with short acting insulin and asked Resident B to administer her own insulin injection. QMA 2 looked uneasy about asking so Resident B administered the insulin injection to herself. QMA 2 was not insulin certified. The clinical record for Resident B was reviewed on 9/16/25 at 12:14 p.m. The diagnoses included, but were not limited to, diabetes and Parkinson's disease and was not cognitively impaired. The current Physician's orders indicated: - Appropriate nursing staff to administer medications, initiated 8/21/24. - Lispro (fast acting insulin prescribed to treat high blood sugar) injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch for diabetes, initiated 11/10/24. A Care Evaluation, dated 9/10/25, indicated Resident B's was dependent on the care team to manage blood glucose monitoring and insulin administration. The Service Plan, dated 9/10/15, indicated Resident B		required. Current community nursing and medication staff have been re-educated on the community's policyby the Interim ED and Director of Health and Wellness for medication administration and resident self-administration competency verification has been completed. An in-service attendance log shall be maintained with the community's training files as evidence of completion of training. **4. Monitoring / Quality Assurance plan:** ¿A **Missed Medication Report** shall be pulled three times per week by the community's Director of Health and Wellness, or their designee, and reviewed for accuracy and completion and sharing the results with the Executive Director weekly. ¿ Twice per month**clinical meetings** shall be held with the Director of Health and Wellness and facility medical providers to review clinical concerns, medication administration accuracy, and resident outcomes. These findings will be documented within the residents clinical chart.	

	required nursing staff assistance for insulin administration. During an interview on 9/17/25 at 8:26 a.m., QMA 2 indicated, on 9/13/25 at approximately 12:00 p.m., she watched the Director of Nursing draw up a dose of lispro insulin for Resident B. QMA 2 took the insulin syringe to Resident B and asked Resident B if she would administer her own insulin injection. QMA 2 felt uncomfortable but had been told by the DON that it was okay for Resident B to administer her own insulin. Resident B administered her own insulin injection. QMA 2 was not certified to administer insulin injections.			

	2. During an interview on 9/17/25 at 9:00 a.m., QMA 3 indicated, on 9/13/25 at approximately 12:00 p.m., she took a fast acting insulin pen to Resident C and asked him if he would administer his own insulin injection with the insulin pen. Resident C said he felt comfortable doing that so he administered the injection. QMA 3 was not certified to administer insulin. There was no insulin certified staff with QMA 3 when Resident C administered the insulin injection. QMA 3 did not feel comfortable but the DON said as long as Resident C administered the insulin to himself this was okay. During an interview on 9/17/25 at 9:12 a.m., Resident C indicated a few days ago, a staff member brought him an insulin pen and asked if he would feel comfortable administering the insulin to himself. Resident C told QMA 3 that he would do it, so he administered the insulin to himself. Resident C was not educated on the pen prior to administration and had not used a pen prior to that. Resident C thought he had administered the injection correctly because he didn't notice anything unusual after the injection. The clinical record for Resident C was reviewed, on 9/17/25 at 9:45 a.m. The diagnoses included, but were not limited to,			

diabetes, disorder of the brain, and macular degeneration.

The current Physician's orders indicated:

- Qualified nursing staff to administer medications, initiated 8/29/24.

-Humalog Kwik Pen (fast acting insulin pen prescribed to treat diabetes) 100 units/milliliter (ml), check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units for diabetes, initiated 7/18/25.

-Humalog Kwik Pen 100 units/ml, administer 12 units subcutaneously three times daily before meals, initiated 7/15/25.

A Care Evaluation, dated 8/28/25, indicated Resident C required care team management of blood glucose monitoring and insulin administration.

A Service Plan, dated 11/25/24, indicated Resident C required nursing staff assistance for

insulin pen administration and blood sugar monitoring.

On 9/16/25 at 11:55 a.m., the DON provided a copy of a facility policy, titled Medication Management, dated 8/11/23, and indicated this was the current policy used by the facility. A review of the policy indicated staff assisting with or administering medication will follow the physician's orders.

This citation relates to Intake IN00464821.

Based on interview and record review, the facility failed to ensure insulin was administered by insulin certified nursing staff for 2 of 3 residents reviewed for insulin administration. Two residents with physician's orders to have qualified nursing staff to administer insulin were asked to administer their own insulin injections by two Qualified Medication Aides (QMA) that were not certified to administer insulin. (Resident B, Resident C)

Findings include:

1. During an interview on 9/16/25 at 9:29 a.m., Resident B indicated, on 9/13/25 at lunch time, QMA 2 entered her apartment with an insulin syringe with short acting insulin and asked Resident B to administer her own insulin injection. QMA 2 looked uneasy

about asking so Resident B administered the insulin injection to herself. QMA 2 was not insulin certified.

The clinical record for Resident B was reviewed on 9/16/25 at 12:14 p.m. The diagnoses included, but were not limited to, diabetes and Parkinson's disease and was not cognitively impaired.

The current Physician's orders indicated:

- Appropriate nursing staff to administer medications, initiated 8/21/24.

- Lispro (fast acting insulin prescribed to treat high blood sugar) injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch for diabetes, initiated 11/10/24.

A Care Evaluation, dated 9/10/25, indicated Resident B's was dependent on the care team to manage blood glucose monitoring and insulin administration.

The Service Plan, dated 9/10/15, indicated Resident B required nursing staff assistance for insulin administration.

During an interview on 9/17/25 at 8:26 a.m., QMA 2 indicated, on 9/13/25 at approximately 12:00 p.m., she watched the Director of Nursing draw up a

	dose of lispro insulin for Resident B. QMA 2 took the insulin syringe to Resident B and asked Resident B if she would administer her own insulin injection. QMA 2 felt uncomfortable but had been told by the DON that it was okay for Resident B to administer her own insulin. Resident B administered her own insulin injection. QMA 2 was not certified to administer insulin injections. 2. During an interview on 9/17/25 at 9:00 a.m., QMA 3 indicated, on 9/13/25 at approximately 12:00 p.m., she took a fast acting insulin pen to Resident C and asked him if he would administer his own insulin injection with the insulin pen. Resident C said he felt comfortable doing that so he administered the injection. QMA 3 was not certified to administer insulin. There was no insulin certified staff with QMA 3 when Resident C administered the insulin injection. QMA 3 did not feel comfortable but the DON said as long as Resident C administered the insulin to himself this was okay. During an interview on 9/17/25 at 9:12 a.m., Resident C indicated a few days ago, a staff member brought him an insulin pen and asked if he would feel comfortable administering the insulin to himself. Resident C			

	told QMA 3 that he would do it, so he administered the insulin to himself. Resident C was not educated on the pen prior to administration and had not used a pen prior to that. Resident C thought he had administered the injection correctly because he didn't notice anything unusual after the injection. The clinical record for Resident C was reviewed, on 9/17/25 at 9:45 a.m. The diagnoses included, but were not limited to, diabetes, disorder of the brain, and macular degeneration. The current Physician's orders indicated: - Qualified nursing staff to administer medications, initiated 8/29/24. -Humalog Kwik Pen (fast acting insulin pen prescribed to treat diabetes) 100 units/milliliter (ml), check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units for diabetes, initiated 7/18/25. -Humalog Kwik Pen 100			

	units/ml, administer 12 units subcutaneously three times daily before meals, initiated 7/15/25. A Care Evaluation, dated 8/28/25, indicated Resident C required care team management of blood glucose monitoring and insulin administration. A Service Plan, dated 11/25/24, indicated Resident C required nursing staff assistance for insulin pen administration and blood sugar monitoring. On 9/16/25 at 11:55 a.m., the DON provided a copy of a facility policy, titled Medication Management, dated 8/11/23, and indicated this was the current policy used by the facility. A review of the policy indicated staff assisting with or administering medication will follow the physician's orders. This citation relates to Intake IN00464821.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:	R 0349	**1. Corrective action for affected resident(s):** The Medication Administration Records for the affected residents were reviewed and corrected. Unclear or missing entries were clarified and resolved.	11/30/2025

(1) Complete.

(2) Accurately documented.

(3) Readily accessible.

(4) Systematically organized.

Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR) documentation was accurate and complete for 2 of 3 residents reviewed for documentation. (Resident B, Resident C)

Findings include:

1. The clinical record for Resident B was reviewed on 9/16/25 at 12:14 p.m. The diagnoses included, but were not limited to, diabetes, Parkinson's disease, and was not cognitively impaired.

The current Physician's orders indicated:

- Basaglar injection (long acting insulin prescribed for diabetes) 100 units/milliliters (ml), inject 38 units subcutaneously at bedtime for diabetes, initiated 9/1/24.

- Lispro (fast acting insulin prescribed to treat high blood sugar) injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch,

2. Identification of other residents potentially affected:
an audit of all current resident MARs was conducted by the Director of Health and Wellness to identify any other residents with missing or incomplete documentation.

3. Systemic changes to prevent recurrence:
Daily staffing assignments continue to ensure that a **Licensed Practical Nurse (LPN)** and/or **insulin-certified QMA** is available for oversight.

Nursing and medication staff have been re-educated on the policy for medication administration and resident self-administration competency verification.

The Director of Health and Wellness has re-in-service Licensed nurses and QMA’s on **Medication Administration Policy** and reinforced during shift huddles, emphasizing that all documentation must be completed at time of administration.

4. Monitoring / Quality Assurance plan:

	initiated 11/10/24. The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated basaglar injection 100 units/milliliters (ml), inject 38 units subcutaneously at bedtime lacked documentation for 2 of 15 administrations as follows: - On 9/2/25 at 7:00 p.m., the MAR was left blank. - On 9/4/25 at 7:00 p.m., the MAR was left blank. The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated lispro injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch for diabetes lacked documentation for 2 of 16 administrations as follows: - On 9/13/25 at 12:00 p.m., the MAR was left blank. - On 9/14/25 at 12:00 p.m., the MAR was left blank. 2. The clinical record for Resident C was reviewed on 9/17/25 at 9:45 a.m. The diagnoses included, but were not limited to, diabetes, disorder of the brain, and macular degeneration. The current Physician's orders indicated:		The Director of Health and Wellness will complete weekly medication audit review for four weeks then monthly for next three months to monitor compliance with documentation. Any findings will be addressed and corrective actions completed as applicable. The Director of Health and Wellness will present all findings and corrective actions to the Executive Director weekly then monthly as indicated above.	

	- Humalog Kwik Pen (fast acting insulin pen prescribed to treat diabetes) 100 units/milliliter (ml), check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units, initiated 7/18/25. - Humalog Kwik Pen 100 units/ml, administer 12 units subcutaneously three times daily before meals for diabetes, initiated 7/15/25.			

	The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated Humalog Kwik Pen 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units for diabetes lacked documentation for 3 of 47 administrations as follows: - On 9/6/25 at 3:00 p.m., the MAR was left blank. - On 9/13/25 at 7:00 a.m., the MAR was left blank. - On 9/13/25 at 11:00 a.m., the MAR was left blank. The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated Humalog Kwik Pen 100 units/ml, administer 12 units subcutaneously three times daily before meals for diabetes lacked documentation for 3 of 47 administrations as follows: - On 9/6/25 at 3:00 p.m., the MAR was left blank.			

- On 9/13/25 at 7:00 a.m., the MAR was left blank.

- On 9/13/25 at 11:00 a.m., the MAR was left blank.

On 9/16/25 at 11:55 a.m., the DON provided a copy of a facility policy, titled Electronic Records, dated 8/19/25, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will maintain accurate records on each resident that are readily available.

During an interview on 9/17/25 at 9:24 a.m., the Director of Nursing (DON) indicated she administered Resident B's and Resident C's insulin injections on 9/13/25 and 9/14/25 during day shift. When the DON was not in the facility, there was an insulin certified Qualified Medication Aide (QMA) to administer the insulin injections. The documentation on the MAR should have been completed.

This citation relates to Intake IN00464821.

Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR) documentation was accurate and complete for 2 of 3 residents reviewed for documentation. (Resident B, Resident C)

Findings include:

1. The clinical record for Resident B was reviewed on 9/16/25 at 12:14 p.m. The diagnoses included, but were not limited to, diabetes, Parkinson's disease, and was not cognitively impaired.

The current Physician's orders indicated:

- Basaglar injection (long acting insulin prescribed for diabetes) 100 units/milliliters (ml), inject 38 units subcutaneously at bedtime for diabetes, initiated 9/1/24.

- Lispro (fast acting insulin prescribed to treat high blood sugar) injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch, initiated 11/10/24.

The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated basaglar injection 100 units/milliliters (ml), inject 38 units subcutaneously at bedtime lacked documentation for 2 of 15 administrations as follows:

- On 9/2/25 at 7:00 p.m., the MAR was left blank.

- On 9/4/25 at 7:00 p.m., the MAR was left blank.

The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00

p.m., indicated lispro injection 100 unit per milliliter (ml), administer 10 units subcutaneously with lunch for diabetes lacked documentation for 2 of 16 administrations as follows:

- On 9/13/25 at 12:00 p.m., the MAR was left blank.

- On 9/14/25 at 12:00 p.m., the MAR was left blank.

2. The clinical record for Resident C was reviewed on 9/17/25 at 9:45 a.m. The diagnoses included, but were not limited to, diabetes, disorder of the brain, and macular degeneration.

The current Physician's orders indicated:

- Humalog Kwik Pen (fast acting insulin pen prescribed to treat diabetes) 100 units/milliliter (ml), check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units, initiated 7/18/25.

- Humalog Kwik Pen 100

units/ml, administer 12 units subcutaneously three times daily before meals for diabetes, initiated 7/15/25.

The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated Humalog Kwik Pen 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale: blood sugar 140-170 administer 2 units, 171-200 administer 4 units, 201-230 administer 8 units, 231-260 administer 10 units, 261-290 administer 12 units, 291-320 administer 14 units, 321-350 administer 16 units, 351-380 administer 18 units, 381-400 administer 20 units for diabetes lacked documentation for 3 of 47 administrations as follows:

- On 9/6/25 at 3:00 p.m., the MAR was left blank.

- On 9/13/25 at 7:00 a.m., the MAR was left blank.

- On 9/13/25 at 11:00 a.m., the MAR was left blank.

The MAR, dated 9/1/25 at 12:00 a.m. through 9/16/25 at 12:00 p.m., indicated Humalog Kwik Pen 100 units/ml, administer 12 units subcutaneously three times daily before meals for diabetes lacked documentation for 3 of 47 administrations as follows:

- On 9/6/25 at 3:00 p.m., the MAR was left blank.

- On 9/13/25 at 7:00 a.m., the MAR was left blank.

- On 9/13/25 at 11:00 a.m., the MAR was left blank.

On 9/16/25 at 11:55 a.m., the DON provided a copy of a facility policy, titled Electronic Records, dated 8/19/25, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will maintain accurate records on each resident that are readily available.

During an interview on 9/17/25 at 9:24 a.m., the Director of Nursing (DON) indicated she administered Resident B's and Resident C's insulin injections on 9/13/25 and 9/14/25 during day shift. When the DON was not in the facility, there was an insulin certified Qualified Medication Aide (QMA) to administer the insulin injections. The documentation on the MAR should have been completed.

This citation relates to Intake IN00464821.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURELorenaGlover	TITLEESL Executive Director	(X6) DATE10/14/2025