STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING -- B. WING	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(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: 11/28/23 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Emergency Preparedness survey, Envive of Berne was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 80 and had a census of 39 at the time of this survey. Quality Review completed on 12/04/23	E 0000	PLAN OF CORRECTION FOR ENVIVE OF BERNE K000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Survey ID324021 completed on November 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 15, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	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: 11/28/2023	K 0000	PLAN OF CORRECTION FOR ENVIVE OF BERNE K000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Diaz	HFA	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

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	Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 At this Life Safety Code survey, Envive of Berne was found not in compliance with 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 one story facility was determined to be of Type V(III) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 80 and had a census of 39 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/04/23		of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Life Safety Survey ID324021 completed on November 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 15, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	155473	A. BUILDING 01 B. WING	11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

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	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 10 residents. Findings include: Based on observation with the Administrator and Facilities Director (FD) on 11/28/23 at 12:55 p.m., the exit door in the Dining room was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, with the FD, the dining room exit door was set up for delayed-egress with the proper signage but the 15 second delay was not working. The FD then removed the 15 second delay signage but with no code posted, the dining room exit door was not readily accessible to residents without a clinical diagnosis requiring specialized security measures. The finding was reviewed with the Administrator and FD during the exit conference. 3.1-19(b)	K 0211	**K211 – Mean of Egress-General SS=E** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities has removed the egress function and signage from the door. The Code was posted by the door, and the door can be opened with	12/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			the posted code The door can also be opened when the fire alarm is activated. See Exhibit 1. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put Into place?** The Executive Director was educated by the Director of Facilities on K221. All exit doors magnetically locked require egress of 15 seconds or the code posted for easy access in the event of an emergency. Door lock test Task has been added the Tels system and is now required to be completed monthly. The results of these audits will be Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:**	

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	155473	A. BUILDING 01 B. WING	11/28/2023

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			12/7/2023	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N).	K 0222	**K222 – Egress Doors** **SS=E** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice.	12/07/2023

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	(b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 35 residents in the Dining room. Findings include: Based on observation during a tour of the facility with the Facilities Director (FD) and Administrator on 11/28/23 at 12:55 p.m., the Dining room exit door was set up for delayed egress with 15 second delay signage. When the exit door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the FD tried 3 times to activate the delay egress and stated the delayed egress was not working and removed the 15 second delay sign. The finding was reviewed with the FD and the Administrator during the exit conference. 3.1-19(b)		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities has removed the egress function and signage from the door. The Code was posted by the door, and the door can be opened with the posted code The door can also be opened when the fire alarm is activated. See Exhibit 1. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put Into place?** The Executive Director was educated by the Director of	

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			Facilities on K222. All exit doors magnetically locked require egress of 15 seconds or the code posted for easy access in the event of an emergency. Door lock test Task has been added the Tels system and is now required to be completed monthly. The results of these audits will be Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** 12/7/2023	
K 0300 SS=F Bldg. 01	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 record review, interview, and observation, the facility failed to ensure	K 0300	**K300 – Protection - Other SS=F**	12/13/2023

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	documentation for the preventative maintenance of 50 of 50 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section14.4.8.1 states unless otherwise recommended by the manufacturer's published 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 all residents, staff, and visitors. Findings include: Based on records review with the Facilities Director (FD) and Administrator on 11/28/23 at 10:55 a.m., no documentation for battery replacement of resident room battery operated smoke alarms was available for review. Based on interview at the time of review, the Facilities Director stated there was no documentation available to show when the last battery replacement of the battery operated smoke detectors was completed. It was observed during the facility tour that the battery operated smoke alarms in the resident room looked to be similar. A battery operated smoke detector was removed from resident room 309. The manufacturers instructions stated that the battery was good for 10 years after installation but there was no		**1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities will Replace ALL battery-operated Smoke dectectors. See Exhibit 2A. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put**	

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	installation date noted. The manufacturers date was March 2012. Using the manufacturers date for reference, the battery operated smoke detector should have been replaced in March 2022. This finding was reviewed with the Administrator and FD at the exit conference. 3.1-19(b)		**Into place?** The Executive Director was educated by the Director of Facilities on K300. ALL Battery-operated devices must be tested per manufactures recommendations, documented, and replaced as needed. Battery operated devices will be tested weekly. This task will be placed into the Tels Building Management system for future scheduling and reminders. The results of these audits will be Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** 12/13/2023; devices were installed. See Exhibit 2B	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the			

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	Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of "Sprinkler System Inspection" documentation dated 01/23/23, 04/06/23, 07/07/23	K 0353	**K353 – Sprinkler System – Maintenance and Testing** **SS=F** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected	12/31/2023

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	and 10/23/23 during record review with the Administrator and Facilities Director (FD) at 11:30 a.m. on 11/28/23, the comment section stated the control valve sign is not in sight. Based on interview at the time of record review, the FD stated the repair has not been completed but provided documentation of a work request confirmed on 11/28/23 by their contracted company to remedy the problem. This finding was reviewed with the Administrator and FD at the exit conference. 3.1-19(b)		by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities has ordered the signage from Elwood Fire Equipment. Elwood said it was mailed on 12/14/23 to the building. Once received it will be installed. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put Into place?** The Executive Director was educated by the Director of Facilities on K353. ANY decencies noted on inspections must be fixed and documented in a timely manner. This task will be placed into the Tels Building Management system for future scheduling and reminders. The results of these audits will be Reviewed by the Safety/QAPI committee	

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			Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** 12/31/2023	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical wirings were protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect staff in the kitchen supply room. Findings include: Based on observation during a tour of the facility with the Facilities Director (FD) on 11/28/23 at 01:00 p.m. in the kitchen supply room there was a ceiling light fixture with the cover missing leaving exposed wires hanging from the light fixture. Based on interview at the time of observation, the	K 0511	**K511 – Utilities-Gas and Electric SS=D** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and**	12/31/2023

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ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(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
	FD acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Administrator and FD at the exit conference. 3.1-19(b)		**what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities will replace the light fixture and insured all wire connections are covered and meet standards in the kitchen supply room. See Exhibit 3. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put Into place?** The Executive Director was educated by the Director of Facilities on K511. All wire/connections must be sealed covered by approved standard. The results of these audits will be Reviewed by the Safety/QAPI committee Overseen by the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	11/28/2023

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			Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** 12/31/2023	
K 0920 SS=D Bldg. 01	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			

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	(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 50 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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. This deficient practice affects 2 residents. Findings include: Based on observation with the Facilities Director (FD) and Administrator on 11/28/23 at 01:20 p.m., resident rooms 400 and 414 contained a multi-plug adaptor powering electronic equipment. Based on interview at the time of observations, the FD and Administrator agreed a multi-plug adaptor was in use in room 400 and 414. The multi-plug adapters were removed at the time of observation. These findings were reviewed at the exit conference. 3.1-19(b)	K 0920	**K920 – Electrical Equipment-Power cords and Extensions SS=D** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** No residents were affected By this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice **3. What measures will be put in place or what systemic changes will be made to Ensure that the deficient Practice does not occur?** The Director of Facilities has removed all multi plugs in resident rooms. **4. How the corrective action will be monitored to**	12/12/2023

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put Into place? The Executive Director was educated by the Director of Facilities on K920 Multi plug adaptors are not permitted. Only approved URL rated surge protectors can be used. Extension cords/adapters will be done twice a week for 4 weeks, once a week for 4 weeks, then monthly for 4 months for a total of 6 months. The results of these audits will be Reviewed by the Safety/QAPI committee Overseen by the Executive Director and/or Maintenance Director. The results will be reviewed for Patterns, trends and continued Recommendations for process Monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** 12/12/2023	