STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155249	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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: 09/12/23 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Emergency Preparedness survey, Chateau Rehabilitation and Healthcare Center 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 99 and had a census of 80 at the time of this survey. Quality Review completed on 09/15/23	E 0000		
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: 09/12/2023 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Life Safety Code survey, Chateau Rehabilitation and Healthcare Center was found not in compliance with Requirements for	K 0000	Hello, We would like to respectfully request paper compliance for this Life Safety Code Recertification and State Licensure Survey. Supporting documents will be uploaded in the portal. Thank you, Cathy Vasil, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Vasil	Executive Director	09/29/2023

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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	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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors, and in the resident sleeping rooms. The facility has a capacity of 99 and had a census of 80 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 09/15/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 maintain latching hardware on 1 of 7 smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and up to 30 residents. Findings include:	K 0100	K100 General requirements – Other The facility requests paper compliance for this citation. *This plan of correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	09/30/2023

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CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

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	Based on observation with the Maintenance Director (MD) on 09/12/23 at 2:45 p.m., the set of smoke barrier doors by the Beauty shop were provided with latching hardware but failed to close and latch when tested. Based on interview at the time of observation, the MD agreed the smoke doors were equipped with latching devices, but the doors did not properly close and latch when tested. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1) Immediate actions taken for those residents identified: No resident was found to the affected by the finding. 2) How the facility identified other residents: Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/System changes Latching hardware on fire door was repaired and is fully functional. 4) How the corrective action will be monitored: The Maintenance Director/designee will present weekly fire door audits to the QAPI Committee during QAPI meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will	

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			identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of Compliance: 30 September 2023	
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 1. Based on observation and interview, the facility failed to maintain 2 of 12 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect 20 residents in the Dining room and 10 residents needing to exit from the Activities room. Findings include: Based on observations with the Maintenance Director (MD) on 09/12/23 between 1:30 p.m. and 2:40 p.m., the #9 exit door from the Dining room and the outside exit door from the Activity room were equipped with panic hardware, however, the door would not open on the first try. It took the MD three tries to open the door and took	K 0211	**K211 Means of Egress - General** **The facility requests paper compliance for this citation.¿** ***This plan of correction is the facility's credible allegation of compliance.¿*** ¿ ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿***	09/30/2023

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	excessive force to open the door on the fourth try. Based on interview at the time of observation, the MD agreed it took excessive force to open the exit door. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 10 residents in the 100 Hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director (MD) on 09/12/23 at 2:50 p.m., in the 100 Hall a Personal Protective Equipment (PPE) cart was in use but was not equipped with wheels allowing the cart to		**1)Immediate actions taken for those residents identified:¿ No resident was found to be affected by the finding.¿ 2)How the facility identified other residents:¿ Visitors, staff, and residents that reside the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ Egress doors for both the dining hall, as well as the activity room, have been repaired and are fully functional. Wheels were added to the PPE cart in question. 4)How the corrective action will be monitored:¿ The Maintenance Director/designee will present weekly audits of both egress doors and means of egress to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or**	

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	be moved out of the halls during an emergency. The PPE cart was observed by room 138. Based on an interview at the time of observations, the Maintenance Director (MD) agreed the PPE cart was not equipped with wheels and added wheels at the time of discovery. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**patterns and make recommendations to revise the plan of correction as indicated.¿** ¿ **5) Date of Compliance: 30 September 2023**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops			

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	d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 5 of 5 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 09/12/23 between 1:40 p.m. and 2:40 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The Activity room which was larger than 50 square feet and contained over 20 boxes of supplies was not self-closing. b) The Housekeeping storage room #250 which was larger than 50 square feet and contained over 20 boxes of supplies was not self-closing. c) The Laundry soiled utility room which contained trash and dirty linen did not latch into the frame. d) The Therapy storage room which contained large amounts of combustibles and was larger than 50 square feet did not latch into the frame. e) The Kitchen dishwashing room, which contained large amounts of combustibles, corridor door did not latch into the frame. Based on interview at the time of observations,	K 0321	K321 Hazardous Areas – Enclosure The facility requests paper compliance for this citation.¿ This plan of correction is the facility's credible allegation of compliance.¿ ¿ Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿ 1)Immediate actions taken for those residents identified:¿	09/29/2023

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	the Maintenance Director agreed all five rooms were hazardous storage areas, and the doors to the rooms were not self-closing or did not latch into the frame. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		No resident was found to be affected by the finding.¿ 2)How the facility identified other residents:¿ Visitors, staff, and residents that reside the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ Automatic door closers have been added or repaired on the following doors: Activity room storage, storage, and Therapy room storage. Latching hardware has been repaired on the following doors: Laundry soiled utility room and Kitchen dishwashing room. 4)How the corrective action will be monitored:¿ The Maintenance Director/designee will audit five	

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			doors for proper closing and latching weekly. Maintenance Director/Designee will monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.¿ ¿ 5) Date of Compliance: 30 September 2023	
K 0363 SS=E Bldg. 01	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			

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	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 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 1 corridor door was 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 in room 12. Findings include: Based on observation with the Maintenance Director (MD) on 09/12/23 at 3:00 p.m., the corridor door to Shower room B2 would not close and latch into the frame when tested. Based on interview at the time of observation, the MD	K 0363	K363 Corridor - Doors The facility requests paper compliance for this citation.¿ This plan of correction is the facility's credible allegation of compliance.¿ ¿ Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it	09/30/2023

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	agreed the corridor door to shower room B2 would not close and latch into the door frame. The finding was reviewed with the Administrator and MD during the exit conference. 3.1-19(b)		is required by the provisions of federal and state law.¿ 1)Immediate actions taken for those residents identified:¿ No resident was found to be affected by the finding.¿ 2)How the facility identified other residents:¿ Visitors, staff, and residents that reside the community have the potential to be affected by the alleged deficient practice.¿ 3)Measures put into place/System changes¿ The B2 shower room latching hardware has been repaired and is fully functional. 4)How the corrective action will be monitored:¿ The Maintenance Director/designee will present a weekly audit of the latching mechanisms of five doors to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.¿ ¿ 5) Date of Compliance: 30 September 2023	
K 0511 SS=E 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			

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	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 2 electrical wiring's 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 5 residents in the vicinity of exit C3. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) on 09/12/23 between 1:50 p.m. and 2:10 p.m., at the 300 C# exit there was an outside light that originally had 2 light bulbs but one had broken off leaving exposed wires at the open end of the light fixture. At the generator, the battery back up emergency light was hanging from the wires. It was not secured, exposing the wires and putting stress on the wires. Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned conditions and confirmed that exposed wiring was visible at both locations. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)	K 0511	**K511 Utilities - Gas and Electric** **The facility requests paper compliance for this citation.** ***This plan of correction is the facility's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice.**	09/30/2023

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			3)Measures put into place/System changes **The egress lighting fixture outside of hall C3 has been replaced and is fully functional.** **The emergency lighting fixture near the generator has been repaired and is fully functional.** **4)How the corrective action will be monitored:** **The Maintenance Director/designee will present a weekly audit of five emergency/egress lighting fixtures monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5)Date of Compliance: 30 September 2023**	
K 0920 SS=E	NFPA 101 Electrical Equipment - Power Cords and			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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
Bldg. 01	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			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in the B Wing pantry area. Findings include: Based on observations during a tour of the facility with the Maintenance Director (MD) on 09/12/23	K 0920	**K920 Electrical Equipment – Power Cords and Extension Cords** **The facility requests paper compliance for this citation.¿** ***This plan of correction is the facility's credible allegation of compliance.¿*** ¿ ***Preparation and/or execution of this plan of correction does not constitute admission or***	09/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 01 B. WING	09/12/2023

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	at 2:50 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the B Wing pantry. Based on interview at the time of observation, the MD acknowledged a power strip was supplying power to high power draw equipment. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 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 1 resident. Findings include: Based on observation with the Maintenance Director (MD) on 09/12/23 at 2:25 p.m., resident room 232 contained a multi-plug adaptor powering equipment. Based on interview at the time of observation, the Maintenance Director agreed a multi-plug adaptor was in use in resident room 232. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) 3. Based on observation and interview, 1 of 1		***agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.¿ The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.¿*** **1)Immediate actions taken for those residents identified:¿ No resident was found to be affected by the finding.¿** **2)How the facility identified other residents:¿ Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice.¿** **3)Measures put into place/System changes: Power strip has been removed from the B Wing pantry.** **The multi-plug adapter has been removed from room 232 and has been replaced with a UL 1363A or UL 60601-1 compliant power strip.** **The power strip in room 202 has been removed.** **4)How the corrective action will be monitored:¿** **The Maintenance**	

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	extension cords including power strips used in patient care vicinities met UL1363A or UL60601-1. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect 2 residents in sleeping room 202. Findings include: Based on observation with the Maintenance Director (MD) during a tour of the facility at 2:25 p.m. on 09/12/23, it was confirmed the power strip used in the resident care vicinity in resident sleeping room 202 did not meet UL1363A or UL60601-1. Based on interview at the time of observation, the MD acknowledged the aforementioned power strip did not meet UL1363A or UL60601-1. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b)		**Director/designee will present a weekly audit (power strips) of five rooms to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.¿** **¿** **5) Date of Compliance: 30 September 2023**	