STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155486	A. BUILDING -- B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

(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: 11/06/23 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 45 certified beds. At the time of the survey, the census was 10. Quality Review completed on 11/13/23	E 0000	K 000 This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(Roles Under a Waiver Declared by Secretary Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants. Findings include:	E 0026	**Tag E 026** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any resident could be affected when a policy is not found pertaining to the Emergency Preparedness. Middletown Nursing and Rehabilitation Center follows section 1135, but by not	11/25/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., the EPP was missing roles of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Environmental Services Director searched the facility's emergency disaster plan and stated the policy was not in the manual. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present.		having a policy could be confusing to the charge nurse if not aware of the situation. A policy stating the facility follows section 1135 has been added to the EPP. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The facility has implemented a policy stating that we will follow the 1135 waiver, and this will keep current residents and any residents that may be moved to our facility during a catastrophe safe. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A policy for 1135 has been added to the Emergency Preparedness Plan. The Administrator will continue to review the EPP annually and ensure all policies are correct. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Administrator will continue to review the EPP annually and inform the staff of the new policy. -	

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			By what date the systemic changes for each deficiency will be completed: The action was corrected November 16, 2023.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all building occupants. Findings include: Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 generator, which is diesel fired. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located and the Environmental Specialist stated that the supplier told him that they treat the fuel and an annual test was not necessary. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present.	E 0041	**Tag E 041** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any resident could be harmed in the event of a power outage and there is no back-up power. The entire facility is ran by the generator, but the generator could be faulty if it is running bad fuel. The facility will have Schaeffer's test our generator fuel annually. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Fortunately, no residents have been harmed by the generator fuel not being tested. The generator has worked perfectly during any power outage or during a load test. The Maintenance Director will monitor that the fuel is checked annually to ensure the safety of all residents. **What measures will be put into**	11/25/2023

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			place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will have the fuel tested annually. Every time the generator is refueled, the Maintenance Director will refer the annual fuel test to see when the next test is due. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Maintenance Director will have the fuel tested annually. Every time the generator is refueled, the Maintenance Director will review the annual fuel test to see when the next test is due. During our quarterly QA, any upcoming maintenance needs will be discussed to ensure compliance. **By what date the systemic changes for each deficiency will be completed:** Schaeffer representative pulled a fuel sample on November 9, 2023. The results are now pending.	
K 0000 Bldg. 02	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	K 000 This plan of correction is submitted to serve as a credible	

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	Survey Date: 11/06/23 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Life Safety Code survey, Middletown Nursing and Rehabilitation Center 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 facility consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story wing determined to be Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing (Old Hall), and hard-wired smoke detectors in the fifteen resident rooms on the South Wing (New Hall) which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 10 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/13/23		allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors			

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	Based on observation and interview, the facility failed to ensure the means of egress through the Lounge exit was 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 15, staff and visitors if needing to exit the facility. Findings include: Based on observations during a tour of the facility with the Environmental Services Director on 11/06/23 between 11:45 a.m. and 1:30 p.m., the Lounge exit door, marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)	K 0222	**Tag K222** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All residents could be affected in the event of an emergency that requires evacuation if the doors are unable to be opened. In the event of an evacuation all resident, staff and visitors must be able to open the doors even if they are locked doors. Doors must be able after 15 seconds and/or if a keypad is present the code must be accessible. Middletown Nursing and Rehab will ensure all keypads have the code visible in the event of an emergency. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** The key code to all keypads will be made visible by making and label and posting above or on top of the keypads. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist will create a label with the key code and post on top of or above all keypads to ensure that it is visible to all staff and visitors in	11/25/2023

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			the event that there is an evacuation and residents need to be removed. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During the next scheduled QAPI meeting, the posting of key codes will be discussed and ensured that it has been completed. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** The label was completed on November 8, 2023.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on observations during a tour of the facility with the Environmental Services Director on 11/06/23 between 11:45 a.m. and 1:30 p.m., the "Covid Room" marked as an office, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and more than 50 cardboard boxes. The corridor door to this room was not equipped with a self-closing device.	K 0321	**Tag K 321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Using any room as storage, or in this case as our "Covid-19 room", can be very harmful in the event of a fire for all residents. All doors must securely close especially when the room contains combustible material. The covid room door will have a self-closing hinge installed. **How other residents having the**	11/25/2023

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	This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Having a room containing an abundance of combustible material must be monitored very closely. If the room would ever catch fire it will spread very quickly if not contained properly. All staff will be re-educated to ensure all storage doors close after leaving. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator and Environment Specialist will do random walk-thru's, and be sure any storage door is not in compliance is fixed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** During quarterly QA meetings any repairs that the aide's and nurses notice will be passed onto the Environmental Specialist at the point. **By what date the systemic changes for each deficiency will be completed:** The hinge was installed November 16, 2023.	

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K 0361 SS=E Bldg. 02	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 business offices with pass-through windows greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observations during a tour of the facility with the Environmental Services Director on 11/06/23 between 11:45 a.m. and 1:30 p.m., the business Office 2 had pass-through windows that were not protected by electrically supervised automatic smoke detection. Based on interview at the time of observation, the Environmental	K 0361	**Tag K 361** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Middletown Nursing and Rehabilitation Center will have Granau add another smoke detector in business office 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This could affect residents in the event that a fire starts in the “the 2nd business office”, because there is nothing to detect the smoke. The fire could spread to other parts of the building without detecting smoke soon enough. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** When Granua comes back to the facility, we will have them install another smoke detector in the “business office 2”. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	11/25/2023

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	Specialist agreed the windows were each greater than 20 square inches and the business office was not protected by electrically supervised automatic smoke detection. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)		**recur, i.e., what quality assurance program will be put into place:** Administrator and Environmental Specialist will do a walk thru prior to Granau coming to the facility to make sure there is not anything extra we need to have them do. **By what date the systemic changes for each deficiency will be completed:**	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations during a tour of the facility with the Environmental Services Director on 11/06/23 between 11:45 a.m. and 1:30 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Resident Room #104 b) Double door set near the Nurses station This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)	K 0363	**Tag K 363** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** If a resident's door or fire door does not latch properly that could potentially allow smoke to enter in the event of fire and affect residents presiding both in that particular room or corridor. The latches for both resident room #104 door and the fire door have been fixed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** In the event that there is smoke in the building all doors must be properly sealed and close to prevent	11/25/2023

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			smoke inhalation. The latches have been fixed and adjusted for both deficient doors. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be permitted to notify the Environmental Specialist in the event they notice a door not working properly. These are all doors and rooms that nursing, housekeeping and dietary staff may enter and notice an issue. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** During quarterly QA meetings if the staff notices any new issues, it will immediately be brought to the Environmental Specialist's attention if it has not already been done. **By what date the systemic changes for each deficiency will be completed:** The fire door latch and room #104 latch were both fixed on November 10, 2023	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on	K 0712	**Tag K 712**	11/25/2023

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	unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., 7 of 12 quarterly fire drills were conducted near the end of the month, between the 27th and 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The fire alarm system must work properly at all times. An improper operating fire alarm could affect all residents and staff in the event of an actual emergency. To ensure the fire alarm works properly it must be test periodically. The Environmental Specialist does the quarterly tests per regulation, but in order to keep the staff unaware to the best of his ability he will spread out the testing more than before. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents and staff could be affected during a fire. The staff must be aware of their surroundings at all times; so a great practice is by doing fire drills. Staff and residents must be unaware of the drill in order to properly test their ability to function during an actual emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The	

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			Environmental specialist will spread the days and try for different times when doing the drills. There will be some difficulty when performing late second and third shifts, because of the staff being so aware of everyone in and out of the building. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Fire drills will also be discussed during quarterly QA meetings. **By what date the systemic changes for each deficiency will be completed:** Changes have been made immediately.	
K 0761 SS=F Bldg. 02	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in	K 0761	**Tag K 761** IDR - Please See Attachment 1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Grunau inspected doors. Please see attachment. **How other residents having the potential to be affected by the**	11/25/2023

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	155486	A. BUILDING 02 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

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	accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.		**same deficient practice will be identified and what corrective action(s) will be taken:** **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **By what date the systemic changes for each deficiency will be completed:** **IDR**	

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	Findings include: Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., no documentation of an annual inspection for the fire door assemblies was available for review. Based on observation during the tour fire door assemblies were observed where the newly constructed dining room area and old building meet. Based on interview at the time of records review and observation, the Environmental Services Director stated the annual fire door inspection was not completed within the last year. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)			
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests	K 0918	**Tag K 918** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Any resident could be harmed in the event of a power outage and there is no back-up power. The entire facility is ran by the generator, but the generator could be faulty if it is running bad fuel. The facility will have	11/25/2023

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	approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review and interview with the Environmental Services Director and Administrator on 11/06/23 between 9:00 a.m. and 11:45 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 generator, which is Diesel fired. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located and the Environmental Specialist stated that the supplier told him that they treat the fuel and an annual test was not necessary. This finding was acknowledged at the time of discovery by the Environmental Services Director and Administrator and again at the exit conference with the Environmental Services Director and Administrator present. 3.1-19(b)		Schaeffer's test our generator fuel annually. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Fortunately, no residents have been harmed by the generator fuel not being tested. The generator has worked perfectly during any power outage or during a load test. The Maintenance Director will monitor that the fuel is checked annually to ensure the safety of all residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director will have the fuel tested annually. Every time the generator is refueled, the Maintenance Director will refer the annual fuel test to see when the next test is due. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Maintenance Director will have the fuel tested annually. Every time the generator is refueled, the Maintenance Director will refer the annual fuel	

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			test to see when the next test is due. During our quarterly QA, any upcoming maintenance needs will be discussed to ensure compliance. **By what date the systemic changes for each deficiency will be completed:** Schaeffer representative pulled a fuel sample on November 9, 2023. The results are now pending.	