STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(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: 05/02/24 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Emergency Preparedness survey, Westpark A Waters Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 89 certified beds. At the time of the survey, the census was 43. Quality Review completed on 05/03/24	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kesha LaGrone	HFA	05/15/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	05/02/2024

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	**E004** – It is the intent of the facility to ensure to develop and maintain	05/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	05/02/2024

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 05/02/24 at 9:15 a.m. with the Maintenance Director present, documentation for an updated emergency preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented update being listed as 04/13/2022. Based on interview at the time of record review, the Maintenance Director said the facility had recently hired a new Administrator and that she had not yet had an opportunity to review the emergency preparedness plan as of time and date of this survey.		an emergency preparedness plan that is reviewed and updated at least annually in accordance with 42 CFR 483.73(a) to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 5/6/2024 the Administrator/DON/Maintenance Supervisor/designee updated the emergency preparedness program and reviewed the plan with all staff to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 5/6/2024 the Administrator in serviced the DON /Maintenance Supervisor on the requirement to update and review the emergency preparedness program annually to meet set standards. The Administrator in serviced all staff on the updated emergency preparedness program on 5/6/2024 . b Maintenance Supervisor/DON/ designee will work with the Administrator to ensure the emergency preparedness program/plan is updated annually and reviewed to meet set standards. If any issues are discovered, they will be addressed and resolved immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING -- B. WING	05/02/2024

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			c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5**/6/2024**.**	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)			

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	155389	A. BUILDING -- B. WING	05/02/2024

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	Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

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	communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop, implement, and update emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 05/02/24 at 9:15 a.m. with the Maintenance Director present, documentation	E 0013	**E013 –** It is the intent of the facility to ensure to develop, implement and update emergency preparedness policies and procedures to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On5/6/2024 the Maintenance Supervisor/DON/Administrator reviewed and updated the policies and procedures in the emergency plan to meet set standards.	05/06/2024

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	for updated policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past twelve months with the last documented update being listed as 04/13/2022. Based on interview at the time of record review, the Maintenance Director said the facility had recently hired a new Administrator and that she had not yet had an opportunity to review the emergency preparedness plan as of time and date of this survey.		2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On the5/6/2024 Administrator in serviced the DON/ Maintenance Supervisor on the requirement to review and update the policies and procedures in the emergency plan annually to meet set standards. The Administrator in serviced all staff on the updated emergency preparedness program on5/6/2024. b The Administrator/Maintenance Supervisor/designee will ensure to review and update the policies and procedures in the emergency plans annually to meet set standards. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual to ensure it includes a letter from their natural gas provider to meet set standards. Those reviews will be documented as appropriate.	

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			The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/6/2024.**	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies	E 0029	**E029** – It is the intent of the facility to ensure to develop and maintain an emergency	05/06/2024

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	with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 05/02/24 at 9:15 a.m. with the Maintenance Director present, documentation for an updated communications plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past twelve months with the last documented update being listed as 04/13/2022. Based on interview at the time of record review, the Maintenance Director said the facility had recently hired a new Administrator and that she had not yet had an opportunity to review the emergency preparedness plan as of time and date of this survey.		preparedness preparedness communication plan that complies with Federal, State and local laws in accordance with 42 CFR 483.73(c) to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 5/6/2024 the Administrator and the DON/Maintenance Supervisor/designee reviewed and updated the communications plan in the emergency plan to meet set standards. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 5/6/2024 the Administrator in serviced the DON/Maintenance Supervisor/designee on the requirement to ensure to update the communications plan in the emergency plan annually to meet set standards. The Administrator in serviced all staff on the updated communication plan on 5/6/2024. b DON/Maintenance Supervisor/designee will work with the Administrator to ensure to update the communications plan in the emergency plan to meet set standards. If any issues are discovered, they will be addressed	

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			and resolved immediately. c The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/6/2024.**	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d),			

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	491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.			

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	*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan on 05/02/24 at 9:15 a.m. with	E 0036	E036 – It is the intent of the facility to ensure to develop and maintain an emergency preparedness training and testing program that is reviewed and updated annually in accordance with 42 CFR 483.73 (d) to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On 5/6/2024 the Administrator	05/07/2024

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WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

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	the Maintenance Director present, documentation for an updated training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past twelve months with the last documented update being listed as 04/13/2022. Based on interview at the time of record review, the Maintenance Director said the facility had recently hired a new Administrator and that she had not yet had an opportunity to review the emergency preparedness plan as of time and date of this survey.		and DON/Maintenance Supervisor/designee reviewed and updated the training and testing program in the emergency preparedness plan to meet set standards. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED: a. All residents and all staff and visitors have the potential to be affected but none were. 3. MEASURES TO PREVENT REOCCURRENCE: a. On 5/6/2024 the Administrator in serviced DON/Maintenance Supervisor/designee on the requirement to review and update the training and testing program in the emergency preparedness plan to meet set standards. b. DON/Maintenance Supervisor/designee will work with the Administrator to ensure to review and update the training and testing program in the emergency preparedness plan to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the	

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	155389	A. BUILDING -- B. WING	05/02/2024

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			Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/6/2024.	
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: 05/02/24 Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410 At this Life Safety Code survey, Westpark A Waters Community was found not in compliance with Requirements for Participation in	K 0000		

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	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 consisted of two sections: the original section determined to be Type III (200) construction and an addition, built in 2003 was determined to be Type V (000) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 43 at the time of this visit. All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered. Quality Review completed on 05/03/24			
K 0353 SS=E 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 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			

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	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 observation and interview, the facility failed to ensure 2 of 2 sprinkler heads located at the main entrance overhang were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect as many as 4 staff, 4 residents, and 2 visitors. Findings include: Based on observation made with the Maintenance Director during a tour of the facility at 12:30 p.m.	K 0353	**K353** – It is the intent of the facility to ensure sprinkler heads located at the main entrance overhang are replaced or cleaned in accordance with NFPA 25 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 5/6/2024 the facilities licensed sprinkler contractor replaced both sprinkler heads located outside the facility main entrance to meet set standards. The Administrator verified the work on 5/6/2024. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 5/6/2024 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to maintain sprinkler systems and to ensure sprinkler heads are not corroded or green to meet set standards. 2.Maintenance Supervisor/designee will ensure to maintain sprinkler systems and to	05/06/2024

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	on 05/02/24, both sprinkler heads located outside the facility main entrance protecting the main entry overhang were corroded, green, and needed to be replaced. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinklers were dirty and showed signs of corrosion, adding that he would contact his vendor and have them replaced as soon as he could. This finding was reviewed with the Administrator, the Maintenance Director, and the Maintenance Assistant at the exit conference on 05/02/24 at 2:00 p.m. 3.1-19(b)		ensure sprinkler heads are not corroded or green as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/6/2024.**	

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