STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING -- B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 E STATE BLVD 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: 08/29/23 Facility Number: 000214 Provider Number: 155321 AIM Number: 100267240 At this Emergency Preparedness survey, The Waters of Fort Wayne Skilled Nursing Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 77 and had a census of 41 at the time of this survey. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 09/05/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy / Lawson	Administrator	09/18/2023

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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	155321	A. BUILDING -- B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 E STATE BLVD FORT WAYNE, IN 46815

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	Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency			

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	preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.			

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	(iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			

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	Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 08/29/23 at 11:11 a.m., no documentation of the annual EPP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was not conducted within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0037	**E037** – It is the intent of the facility to ensure to conduct annual training for the Emergency Preparedness Program to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On _____ 09/14/2023 _____ the Administrator and the Maintenance Supervisor/DON/ designee updated the facilities emergency preparedness binder to include all staff receive initial and annual emergency preparedness training including a tracking record with a roster of all current employees and their start dates and the dates of initial and annual emergency plan training to meet set standards. b On _____ 09/14/2023 _____ The Administrator inserviced all staff on the emergency preparedness plan and documented the results on the facilities emergency preparedness training sheet and any new employees will be added to the training sheet upon hire during general orientation and document on the emergency preparedness training sheet as their initial training. **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**:	09/15/2023

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			a On _____ 09/14/2023 _____ the Administrator inserviced all Department heads on the requirement that the Emergency Preparedness Policy Manual must be reviewed and updated upon hire and at least annually for all staff and documented to meet set standards. b Maintenance Supervisor/designee will work with the Administrator to update the Emergency Preparedness Policy Manual yearly and reviewed with all staff annually 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 Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual 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	

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			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** _____ 09/15/2023 _____**.**	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/29/23 Facility Number: 000214 Provider Number: 155321 AIM Number: 100267240 At this LSC survey, The Waters of Fort Wayne Skilled Nursing Facility 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. The original 1964 one-story facility with a walkout lower level was determined to be of Type II (111) construction and the 2015 constructed therapy gym was determined to be of Type V (111) and	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	

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	was separated from the original building by a two-hour fire barrier. The facility is fully sprinklered, has a fire alarm system with hard wired smoke detectors in the corridors, areas open to the corridors, and in the resident rooms. The facility is partially protected by a Type II EES 160 kW diesel power generator. The facility has a capacity of 77 and had a census of 41 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached shed that was not sprinklered. Quality Review completed on 09/05/23			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview, the facility failed to ensure 2 of 2 battery backup lights were properly tested. Section 7.9.3.1.1 requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 10 staff and residents using in the therapy gym. Findings include:	K 0291	**K291** – It is the intent of the facility to ensure battery backup emergency lights are properly tested to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On _____ 09/11/2023 _____ the Maintenance Supervisor/designee conducted the monthly and annual testing for the battery backup emergency lights and documented the results on the Battery-Operated Emergency Lights and signs Test Log to meet set standards. The Administrator verified the work on _____	09/15/2023

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	Based on observation with the Maintenance Director and Administrator on 08/29/23 at 12:40 p.m., there were two battery-operated emergency lights in the therapy gym. Based on records review at 1:20 p.m., the annual and monthly testing documentation for the battery powered emergency lights were not available for review. Based on an interview at the time of record review and observation, the Maintenance Director confirmed there were battery powered lights in the therapy gym and stated the lights were not tested annually and monthly within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		09/11/2023 _____ . **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 _____ 09/14/2023 _____ the Administrator inserviced the Maintenance Supervisor/designee on the requirement to provide and maintain emergency lighting and conduct the monthly and annual testing and document the results to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain emergency lighting and conduct the monthly and annual testing as a part of the facility's Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. 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.	

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			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** _____ 09/15/2023 _____.	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained for 3 of 3 electrical power panels. NFPA 99, Health Care Facilities Code, 2012	K 0911	**K911 -** It is the intent of the facility to ensure access and working space is maintained for electrical power panels to meet set	09/15/2023

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	Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect staff in the service hall. Findings include: Based on observations with the Maintenance Director and the and Administrator on 08/29/23 at 12:31 p.m., three electrical power panels in the boiler room were block from access with items stored in front of the electrical power panels. Based on interview at the time of the observation, the Maintenance Director agreed items were stored within the working space in front of the electrical power panels.		standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On _____ 08/31/2023 _____ the Maintenance Supervisor/designee removed the items stored in front of the electrical power panels in the boiler room to meet set standards. The Administrator verified removal of the items on _____ 08/31/2023 _____ . 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On _____ 08/31/2023 _____ the Maintenance Supervisor/designee inspected all other areas and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On _____ 09/14/2023 _____ the Administrator inserviced the Maintenance Supervisor/designee and all other staff on the requirement that nothing is to impede access to workspaces including electrical power panels to meet set standards. b Maintenance Supervisor/designee will inspect all electrical power panels throughout the facility weekly to ensure there are no impediments to accessing the panels as a part of the facility's Preventive Maintenance Program and	

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WATERS OF FORT WAYNE SKILLED NURSING FACILITY, THE	5544 E STATE BLVD FORT WAYNE, IN 46815

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	The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		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. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a 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** _____ 09/15/2023 _____.	
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 01 B. WING	08/29/2023

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Bldg. 01	Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.			

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	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room was provided with a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Administrator on 08/29/23 at 12:00 p.m., the oxygen storage room contained oxygen cylinders. The door to the room was not provided with a precautionary sign that indicates storage that stated "CAUTION: OXIDIZING GAS(ES) STORED". Based on interview at the time of observation, the Administrator stated there was not a precautionary sign that indicates storage of oxidizing gasses. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0923	**K923** – It is the intent of the facility to ensure oxygen storage rooms are provided with a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum “Caution: Oxidizing gases stored” to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On _____ 09/01/2023 _____ the Maintenance Supervisor/Director of Nursing/designee installed signage in the Oxygen Storage Room stating “Caution: Oxidizing Gas(es) stored” to meet set standards. The Administrator verified the work on _____ 09/01/2023 _____ . 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. On _____ 09/01/2023 _____ DON/designee checked all areas of the facility and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On _____ 09/14/2023 _____ the Administrator inserviced the DON/Maintenance Supervisor/and all other nursing staff on the requirement that	09/15/2023

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			oxygen storage rooms must have a sign that indicates “Caution: Oxidizing gas(es) stored” to meet set standards. b The Director of Nursing/Maintenance Supervisor will inspect all oxygen storage rooms to ensure they have a sign that indicates “Caution: Oxidizing gas(es) stored” as a part of the facility’s Oxygen Policy and Procedures 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. c The Administrator will monitor adherence to the Oxygen Policy & Procedures schedule and validate the Oxygen Policy & Procedures are in place. 4 **MONITORING CORRECTIVE ACTION**: a 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	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is** _____ 09/15/2023 _____.	