PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

CTATEMENT OF DEFICIENCIES (V1) DROVIDED/CUIDDI IED/CUIA		(X2) MULTIPLE CONSTRUCTION			OVA) DATE CHESTES		
					ì í		
OF CORRECTION							
	155617	B. WI	NG		02/07/	2025	
NAME OF PROVIDER OR SUPPLIER			524 AN	DERSON RD	•		
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY			CHESTERFIELD, IN 46017				
SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CO			(X5)	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/07/25  Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR		E 0000		Preparation and/or execution of this plan of correction in general, or this corrective action, 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			
census of 43 at the t	time of this survey.						
Licensure Survey w Department of Heal 483.90(a).  Survey Date: 02/07  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety s Skilled Nursing Fac	ras conducted by the Indiana th in accordance with 42 CFR  /25  /25  /25  /267090  survey, Waters of Chesterfield cility was found not in	K 0	000	of this plan of correction in general, or this corrective action, does not constitute a admission or agreement by facility of the facts alleged o conclusions set forth in this statement of deficiencies. T plan of correction and speci corrective actions are prepa and/or executed in complian with state and federal laws. This plan of correction	nn this r he fic red ace		
	An Emergency Preparation of the starting Provider Number: 1002  At this Emergency of Chesterfield Skilling in compliance with Requirements for Mean Participating Provider Number: 1002  At this Emergency of Chesterfield Skilling compliance with Requirements for Mean Participating Provider Number: 1002  At this Emergency of Chesterfield Skilling Compliance with Requirements for Mean Participating Provider Number: 1002  At Life Safety Code Licensure Survey we Department of Heal 483.90(a).  Survey Date: 02/07.  Facility Number: 1002  At this Life Safety Skilled Nursing Facility Nursing Facility Skilled Nursing Facility Number: 1002	OF CORRECTION IDENTIFICATION NUMBER 155617  PROVIDER OR SUPPLIER  SOF CHESTERFIELD SKILLED NURSING FACILITY  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/07/25  Facility Number: 000524  Provider Number: 155617  AIM Number: 100267090  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility 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 60 and had a census of 43 at the time of this survey.  Quality Review completed on 02/11/25  A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	PROVIDER OR SUPPLIER  SOF CHESTERFIELD SKILLED NURSING FACILITY  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/07/25  Facility Number: 100267090  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility 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 60 and had a census of 43 at the time of this survey.  Quality Review completed on 02/11/25  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: 02/07/25  Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090  At this Life Safety survey, Waters of Chesterfield Skilled Nursing Facility was found not in	DENTIFICATION NUMBER 155617  STREET A 524 AN CHEST CHESTERFIELD SKILLED NURSING FACILITY  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/07/25  Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility 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 60 and had a census of 43 at the time of this survey.  Quality Review completed on 02/11/25  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: 02/07/25  Facility Number: 000524 Provider Number: 155617 AIM Number: 100267090  At this Life Safety survey, Waters of Chesterfield Skilled Nursing Facility was found not in	PROVIDER OR SUPPLIER  S OF CHESTERFIELD SKILLED NURSING FACILITY  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PIRECEDED BY FULL REGULATORY OR LSC IDENTIFYING NPORMATION  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 02/07/25  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility 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 60 and had a census of 43 at the time of this survey.  Quality Review completed on 02/11/25  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).  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).  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).  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).  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).  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Survey Date: 02/07/25  At this Emergency Preparedness survey, Waters of Chesterfield Skilled Nursing Facility 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 60 and had a census of 43 at the time of this survey.  Quality Review completed on 02/11/25  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).  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).  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).  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).  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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Eileen R Thomas HFA Administrator 02/21/2025

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.

Event ID: I5J421 Facility ID: 000524 If continuation sheet Page 1 of 7

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i ´					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155617	B. WI	NG		02/07/	2025
NAME OF PROVIDER OR SUPPLIER WATERS OF CHESTERFIELD SKILLED NURSING FACILITY		•	524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDENCE N. AV OF CORD			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		, 42 CFR Subpart 483.90(a),			of substantial compliance wi	th	
	•	re and the 2012 edition of the			Federal Medicare and		
		ction Association (NFPA) 101,			Medicaid requirements.		
		LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	This one-story facil	ity was determined to be of					
	_	ruction and was fully					
		cility has a fire alarm system					
	_	on in the corridors, areas open					
to the corridors and battery-operated smoke							
	detectors in the resident sleeping rooms. The						
	facility has a capacity of 60 and had a census of						
	43 at the time of this	s survey.					
	All areas where the	residents have customary					
	_	ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 02/11/25					
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01							
		on and interview, the facility	K 03	321	K321– It is the intent of the fac	•	02/28/2025
	failed to ensure 1 of 1 rooms greater than 50 square feet and being used for storage of large				to ensure rooms greater than		
	_				square feet and being used fo	Ī	
	amounts of combustibles was protected as a hazardous area. This deficient practice could				storage of large amounts of		
		n one smoke compartment.			combustibles are protected as hazardous area to meet set	d	
	affect 20 fesidents i	n one smoke compartment.			standards.		
	Findings include:				1 CORRECTIVE ACTIONS		
	- mamgo morado.				TAKEN:		
	Based on observation	ons with the Administrator on			a On 2.14.2025 the		
		.m., the schedulers office			Maintenance Supervisor/desig	nee	
		of combustibles supplies, was			installed a self-closer to the do		
		are feet, therefore making the			to the schedulers office to mee		
	-	rea. The room was not			set standards. The Administra	tor	
	protected as a hazar	dous area because the			verified the work.		
	corridor door to the room was not self-closing or				2 ALL OTHERS WITH		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAD SERVICES

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STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155617	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  02/07/2025	
	PROVIDER OR SUPPLIER	LD SKILLED NURSING FACILIT	524 AN	ADDRESS, CITY, STATE, ZIP COD IDERSON RD FERFIELD, IN 46017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	automatic closing. I time of observation schedulers office co combustible storage feet, and the corrido self-closing.	Based on an interview at the , the Administrator agreed the ontained large amount of e, was larger than 50 square or door to the room was not viewed with the Administrator		POTENTIAL TO BE AFFECT a All residents and all staff visitors have the potential to be affected but none were.  3 MEASURES TO PREVE REOCCURRENCE: a On 2.17.2025 the Administrator inserviced the Maintenance Supervisor/ des to ensure rooms greater than square feet and being used for storage of large combustibles protected as a hazardous are meet set standards. b Maintenance Supervisor/designee will ensurooms greater than 50 square and being used for storage of combustibles are protected as hazardous area as a part of th facility's monthly Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. Th Maintenance Supervisor/design will review with the Administrate 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 w	ED: i and ignee  NT  ignee 50  or are a to  ure is feet large is a ne sults are essed ne gnee ator	

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4 1

presented by the Maintenance Supervisor/designee to the

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction 01	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	155617	B. WING	<u>01</u>	02/07/2025
WATERS	T	LD SKILLED NURSING FACILIT	524 AN CHEST	ADDRESS, CITY, STATE, ZIP COD IDERSON RD FERFIELD, IN 46017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE (X5) COMPLETION DATE
				Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained.	nlly ce by
K 0741 SS=E Bldg. 01	failed to ensure 1 or provided with meta	ons on and interview, the facility f 1 smoking areas were l or noncombustible containers over to dispose of cigarette	K 0741	K741 – It is the intent of the facility to ensure smoking area are provided with metal or non-combustible containers w	
	_	t practice could affect staff in		self-closing cover to dispose of cigarette butts to meet set standards.  1 CORRECTIVE ACTIONS	of
	Based on observation of the service	ons with the Administrator on .m., in the staff smoking area is pole that was tipped over so, there was a metal bucket buts with no cover. Based on time of observations, the ed the smoker's pole was a lid off and there was a metal sigarette butts with no cover.		TAKEN:  a On 2.14.2025 the  Housekeeping Supervisor/ Maintenance Supervisor place the smoker's pole upright and secured it and removed the m bucket and placed a fire rated metal cigarette butt can with self-closing lid to meet set standards. The Administrator verified the work.  2 ALL OTHERS WITH POTENTIAL TO BE AFFECTE	ed etal
	3.1-19(b)			a All residents and all staff visitors have the potential to be	

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Event ID:

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Facility ID: 000524

affected but none were.

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EPARTMENT OF HEALTH AND HUN	FORM APPRO		
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A RUILDING 01	COMPLETED

	PLAN OF CORRECTION  TO SERVICE STREET		· ′	JLTIPLE CO ILDING NG	<u>01</u> COMI		E SURVEY PLETED 7/2025	
	ROVIDER OR SUPPLIE	R RELIGIOUS SKILLED NURSING FACILITY	,	524 AN	ADDRESS, CITY, STATE, ZIP COD DERSON RD ERFIELD, IN 46017			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
					REOCCURRENCE: a On 2.17.2025 the Administrator inserviced the Maintenance Supervisor/designee/all staff to ensure smoking areas are provided with metal or non-combustible containers to meet set standards. b Maintenance Supervisor/Administrator/DON sekeeping Supervisor/designe will conduct weekly inspection the property to ensure smoking areas are provided with metal non-combustible containers as part of the facilities preventation maintenance program. If any issues are discovered, they will addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Smoth Policy and validate the Preventative Maintenance documentation is in place. 4 MONITORING CORRECTIVE ACTION: a The inspection results will presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the month Quality Assurance/Performance Improvement (QA/PI) meeting	ol/Houles son gors a ve		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>01</u>			COMPLETED	
		155617	B. W	ING		02/07/2025		
				STREET .	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	R		524 AN	IDERSON RD			
WATERS	S OF CHESTERFIE	LD SKILLED NURSING FACILIT	Υ	CHEST	TERFIELD, IN 46017			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
					Inspection results and system			
					components will be reviewed I	by		
					the QA/PI Committee with			
					subsequent plans of correction			
					developed and implemented a	IS		
					deemed necessary to ensure			
					compliance is maintained.			
K 0927	NFPA 101							
SS=E	_	Transfilling Cylinders						
Bldg. 01	Oas Equipment	Transming Cymricis						
Diag. 01	Based on observation	on and interview, the facility	K 0	927	K927- It is the intent of the fac	cility	02/28/2025	
	failed to ensure transfilling of oxygen took place			121	to ensure transfilling of oxyger	-	02/20/2023	
		insfilling rooms that are			took place in oxygen transfilling			
		portion of a facility, NFPA 99			rooms that are separated from	_		
		3.1, Transfilling to liquid			portion of a facility, NFPA 99 2	-		
		oir containers or to liquid			edition 11.5.2.3.1, transfilling t			
		ntainers over 344.74 kPa (50			liquid oxygen base reservoir	.0		
	psi) shall include th	•			containers or to liquid oxygen			
		ea separated from any portion			portable containers over 344.7	74		
		n patients are housed,			kPa to meet set standards.	•		
	-	d by a fire barrier of 1 hour			1 CORRECTIVE ACTIONS	;		
	fire-resistive constr	_			TAKEN:			
	(2) The area is med	hanically ventilated, is			a On 2.17.2025 the			
	sprinklered, and has	s ceramic or concrete flooring.			DON/Maintenance Supervisor			
	(3) The area is post	ed with signs indicating that			rearranged some of the liquid			
	transfilling is occur	ring and that smoking in the			oxygen tanks from the oxygen	1		
	immediate area is not permitted.  (4) The individual transfilling the container(s) has				storage/transfilling room to en			
					a person transfilling oxygen ha			
	been properly traine	ed in the transfilling			enough room to transfill while			
	procedures.	-			door is shut to meet set			
	This deficient pract	cice could affect up to 20			standards. The Administrator			
	residents in one sm	oke compartment.			verified the work			
					2 ALL OTHERS WITH			
	Findings include:				POTENTAL TO BE AFFECTE	D:		
					a All residents and all staff	and		
	Based on observation	ons with the Administrator on			visitors have the potential to b	е		
	02/07/25 at 12:05 p	.m., the oxygen storage/transfer			affected but none were.			

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room contained four liquid oxygen tanks

completely filling the room. This condition does

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**MEASURES TO PREVENT** 

REOCCURRENCE:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PLAN OF CORRECTION IDENTIFICATION NUMBER		· /	JILDING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 02/07/2025	
NAME OF P	ROVIDER OR SUPPLIER	<del>.</del> }	-		ADDRESS, CITY, STATE, ZIP COD	-	
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY				DERSON RD ERFIELD, IN 46017			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	oom for a person transfilling oom with the door closed.			1.On 2.17.2025 the		
		at the time of observation, the			Administrator inserviced the		
		d staff can not fit inside the			DON/and all nursing staff/Maintenance Supervisor	on	
		pably are not transfilling in the			the requirement to ensure the		
	room with the door	· ·			oxygen storage/transfilling roo		
					has enough room for a persor		
	This finding was re	viewed with the Administrator			transfilling oxygen to meet se		
	during the exit conf	Perence.			standards.		
					2.Maintenance		
	3.1-19(b)				Supervisor/DON will ensure the		
					oxygen storage/transfilling roo		
					has enough room for a person		
					transfilling oxygen as a part o	t the	
					facility's Oxygen Policy and		
					Procedures and document the inspection results as appropri		
					If any issues are discovered,		
					will be addressed and resolve	-	
					immediately. The Maintenand		
					Supervisor/DON/designee wil		
					review with the Administrator		
					inspection results.		
					4 MONITORING		
					CORRECTIVE ACTION:		
					a The inspection results w		
					presented by the DON/design		
					the Administrator monthly and	i ine	
					Administrator will present the inspection results at the mont	hlv	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed		
					the QA/PI Committee with	•	
					subsequent plans of correctio	n	
					developed and implemented	as	
					deemed necessary to ensure		
					compliance is maintained.		

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