STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155200	A. BUILDING -- B. WING	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/07/24 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 At this Emergency Preparedness survey, University Nursing Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 75 and had a census of 67 at the time of this survey. Quality Review completed on 11/12/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/07/24 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 At this Life Safety Code survey, University Nursing Center was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bishir	Executive Director	11/25/2024

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.

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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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 67 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility had a storage shed of maintenance supplies that was not sprinklered. Quality Review completed on 11/12/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 2 egress doors from the laundry room met the clear width according to LSC 7.2.1.2.3.2 which states door openings in means of egress shall be not less than 32 in. (810 mm) in clear width. This deficient practice could affect staff in the laundry room. Findings include: Based on observation with the Maintenance Director on 11/07/24 at 11:29 a.m., the clean side laundry room door would only open ½-way due to the shelving behind the door. This condition	K 0211	**K 211 Means of Egress** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents were found to be affected. Shelf inside clean laundry room found to obstruct door was removed by Maintenance director on 11/12/2024. Education to be completed with environmental staff r/t keeping the door clear of obstruction and	12/12/2024

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	reduces the clear width of 32 inches by half. Based on an interview at the time of observation, the Maintenance Director agreed the door would not fully open to the required width of 32 inches. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		maintaining full opening function by 12/6/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected. Maintenance director or designee to complete audit of all aisles, passageways, corridors, exit discharges, exit locations, and accesses to ensure all means of egress are free from obstruction. Education to be completed with all staff r/t importance of keeping all means of egress free from obstruction by 12/6/2024. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education to be completed with all staff r/t importance of keeping all means of egress free from obstruction by 12/6/2024. Maintenance director or designee to round daily to ensure all means of egress are unobstructed. Obstructions identified will be cleared immediately. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this	

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			corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and is overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0324 SS=C Bldg. 01	NFPA 101 Cooking Facilities Based on observation, records review, and interview, the facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems. LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96. NFPA 96 section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Section 10.1.2 states cooking equipment that produces grease-laden	K 0324	**K 324 Cooking Facilities** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. All residents in the main dining were found to be affected. Maintenance director placed distinguished markings per policy to ensure that all cooking equipment is returned to the designated location after they have been moved for maintenance and cleaning on 11/20/2024. Education to all culinary staff to be provided by 12/06/2024 r/t cooking equipment placement and markings. How other residents having the	12/06/2024

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	vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice affects staff in the kitchen and all residents in the main dining room. The findings include: Based on records review with the Maintenance Director and Administrator on 11/07/24 at 12:40 p.m., the kitchen equipment policy indicated all cooking equipment shall be put back in the designed location by aligning the cooking equipment with the markings on the floor. Based on observation at 11:49 a.m., all cooking equipment in the main kitchen were covered by the fire suppression system, but was not provided with markings on the floor according to the facility's policy to ensure cooking appliances were returned to the approved design location after they had been moved for maintenance and cleaning. Based on an interview during observation and records review, the Maintenance Director and Administrator stated there was a written policy for cooking equipment, but the floor did not contain markings to ensure cooking appliances were returned to an approved design location after they had been moved for maintenance and cleaning. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that enter the main dining area have the potential to be affected. Culinary manager or designee to complete audit of cooking equipment and markings to ensure proper placement. Education to all culinary staff to be provided by 12/06/2024 r/t cooking equipment and markings placement. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education to all culinary staff to be provided by 12/06/2024 r/t cooking equipment and markings placement. Culinary manager or designee to check cooking equipment and markings daily to ensure proper placement. Cooking equipment or markings that are found to be out of designated location will be returned immediately or after maintenance/cleaning. Missing distinguished markings will be replaced immediately. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this	

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			corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads in the 300-hall storage closet were in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1which states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0351	**K351 Sprinkler System-Installation** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Potential of 20 residents were found to be affected. Maintenance director removed top shelf in the 300-hall storage closet on 11/12/2024 to ensure 18" clearance of sprinkler head. Education to all staff r/t storage of supplies and sprinkler head obstruction to be completed by 12/06/2024. How other residents having the potential to be affected by the	12/06/2024

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	Based on observation with the Maintenance Director on 11/07/24 at 12:15 p.m., the storage closet in the 300-hall had storage within 8 inches of the sprinkler. Based on an interview at the time of observation, the Maintenance Director agreed the sprinkler head was obstructed and did not have an 18-inch clearance from the storage in the closet. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected. Maintenance director or designee to conduct an audit of all storage areas to ensure items on top shelf do not obstruct sprinkler heads. Education to all staff r/t storage of supplies and sprinkler head obstruction to be completed by 12/06/2024. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education to all staff r/t storage of supplies and sprinkler head obstruction to be completed by 12/06/2024. Maintenance director or designee to check storage closets daily to ensure sprinkler heads are unobstructed. Sprinkler heads that are found to be obstructed will be cleared immediately. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director.	

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			Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 40 resident room corridor doors in the facility were provided with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. This deficient practice could affect 4 residents in rooms 203 and 321. Findings include: Based on observation with the Maintenance Director on 11/07/24 at 11:20 a.m., the corridor doors to resident rooms 203 and 321 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor doors for rooms 203 and 321 would not latch into the door frame because the latch was stuck inside the door and a bent door frame. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0363	**K363 Corridor-Doors** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 4 residents were found to be affected. Maintenance director serviced doors to room 203 and 312 on 11/20/2024 to ensure proper latch when closed. Education to all staff by 12/06/2024 r/t reporting the failure of proper latching of resident doors when closed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance director or	12/06/2024

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	3.1-19(b)		designee to conduct audit of all resident doors for proper latching when closed. Education to all staff by 12/06/2024 r/t reporting the failure of proper latching of resident doors when closed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education to all staff by 12/06/2024 r/t reporting the failure of proper latching of resident doors when closed. Maintenance director or designee to round daily to ensure the proper latching of resident doors when closed. Resident doors noted to not latch properly when closed will be corrected immediately. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be	

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			developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation, records review, and interview, the facility failed to ensure penetrations caused by the passage of wires, pipes, and conduits through 4 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier and to ensure listed firestop systems or devices were used to seal penetrations. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice affects all residents.	K 0372	**K372 Subdivision of Building Spaces-Smoke Barriers** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. All residents were found to be affected. Maintenance Director or designee to ensure all penetrations in smoke barriers on 100-hall, 200-hall, 300-hall, and above the drop ceiling and in the attic of the dining hall are sealed with a firestop system or device tested in accordance with ASTM E 814. To be corrected no later than 12/06/2024. Education for Maintenance Director r/t penetrations and proper sealing with firestop system or device. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance Director or	12/06/2024

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	Findings include: Based on observation with the Maintenance Director on 11/07/24 between 12:20 p.m. and 12:40 p.m., the following unsealed penetrations and penetrations filled with material not listed at ASTM E 814 were discovered: a) Above the drop ceiling and in the attic of the 100-hall smoke wall had 1/4-inch unsealed gaps around wires, and had joint compound, white caulk, and grey caulk to seal penetrations. b) Above the drop ceiling and in the attic of the 200-hall smoke wall had 1/2-inch unsealed gaps around wires and pipes, and had joint compound, white caulk, and grey caulk to seal penetrations. c) Above the drop ceiling and in the attic of the 300-hall smoke wall had an unsealed 6-inch by 3-inch cutout, and had joint compound, white caulk, and grey caulk to seal penetrations. d) Above the drop ceiling and in the attic of the dining hall smoke wall had 1/2-inch unsealed gaps around wires and pipes, and had joint compound, white caulk, and grey caulk to seal penetrations. Based on records review at 12:40 p.m. no documentation was provided to show if the joint compound, white caulk, and grey caulk were listed at ASTM E 814. Based on interview at the time of observation, the Maintenance Director agreed all four smoke walls contained unsealed penetrations and were filled with material without the proper listing of ASTM E 814. The findings were reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		designee to conduct audit of all smoke barriers to ensure proper sealing of penetrations. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Education for Maintenance Director r/t penetrations and proper sealing with firestop system or device. Maintenance Director or designee to check smoke barriers per policy to ensure proper sealing of any old or new penetrations. Smoke barrier penetrations found will be sealed with proper firestop system asap. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	

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K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect all residents that use the main dining room. Findings include: Based on observation with the Maintenance Director on 11/07/24 at 11:25 a.m., the set of smoke barrier doors in the dining room corridor would not close due to one of the doors getting stuck on a high point on the floor. This condition would leave the smoke doors halfway open upon activation of the fire alarm. Based on an interview during the time of observation, the Maintenance Director stated the smoke door would not completely self-close. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0374	**K374 Subdivision of Building Spaces-Smoke Barriers** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. All residents in the main dining room are found to be affected. Maintenance Director adjusted the set of smoke barrier doors in the dining room corridor to ensure proper self-closure with the activation of the fire alarm on 11/20/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance Director or designee to conduct audit of all smoke barrier doors to ensure proper self-closure with activation of the fire alarm. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director or designee to check all smoke barrier doors routinely per policy to ensure proper self-closure with activation of the fire alarm.	12/06/2024

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(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
			Smoke doors found to not properly self-close with activation of the fire alarm will be corrected asap. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 electrical splices in the service hall mechanical room were made in a junction box. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 322.56 (A) states splices shall be made in listed junction boxes. This deficient practice could affect staff in the service hall.	K 0511	**K511 Utilities- Gas and Electric** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents were found to be affected. Maintenance Director placed junction box over spliced electrical	12/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 01 B. WING	11/07/2024

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	Findings include: Based on observation with the Maintenance Director on 11/07/24 at 11:32 a.m., in the service hall mechanical room there were electrical wires spliced together connecting a light that was not contained inside a junction box. Based on an interview at the time of the observation, the Maintenance Director agreed there was an electrical splice that was not protected within a junction box. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		wires to a light inside the mechanical room in the service hall on 11/12/2024. Education for Maintenance Director r/t spliced wires to be properly covered with a junction box by 12/06/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents residing in the facility have the potential to be affected. Maintenance Director or designee to conduct audit of all connecting lights to ensure any splices are properly covered by a junction box. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director or designee to check all connecting lighting fixtures routinely per policy to ensure any splices are covered properly with a junction box. Any spliced wires found without a junction box will be corrected immediately. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with	

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			meetings being held at least bi-monthly, and overseen by the Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 11/07/24 at 11:20 a.m. and 11:33 a.m., a refrigerator (high power draw equipment) was plugged into a power strip in the Administrator's office and a refrigerator was plugged into a multi-plug adaptor in the dietary office. Based on an interview at the time of observation, the Maintenance Director agreed that high power draw equipment were plugged into a power strip	K 0920	**K920 Electrical Equipment-Power Cords and Extension Cords** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Up to 25 residents residents in one smoke compartment were found to be affected. Maintenance Director plugged the appliances found in 2 offices directly into the wall per regulation on 11/07/2024. Education provided to ED and Culinary Director r/t properly plugging appliances directly into the wall outlet on 11/07/2024. How other residents having the potential to be affected by the same deficient practice will be	12/06/2024

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	and a into multi-plug adaptor. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		identified and what corrective action will be taken. All residents have the potential to be affected. All employees with offices to be educated r/t r/t properly plugging appliances directly into the wall outlet by 12/06/2024. Maintenance Director or designee to conduct audit in all offices to ensure any high power draw equipment is plugged in properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance Director or designee to check all offices routinely per policy to ensure any high current draw equipment is plugged into the proper outlet. Any high current draw equipment not plugged into the proper outlet will be corrected immediately. All employees with offices to be educated r/t r/t properly plugging appliances directly into the wall outlet by 12/06/2024. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held at least bi-monthly, and overseen by the	

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			Executive Director. Rounding tool will be completed weekly x's 3 weeks, monthly x's 3 months, and quarterly thereafter until compliance is achieved. If a threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed. 12/6/2024.	