STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Emory Post Acute Care	59 Blackstock Road Inman, SC 29349

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on review of facility policy, record review, and interview, the facility failed to notify the responsible party for Resident (R) 2 and R3, of an elopement, for 2 of 3 residents reviewed for elopement. Findings include: Review of the facility policy titled Elopement dated 11/01/17, documented, When the resident is located . The Director of Nurses or the designee notifies the Administrator/designee and notifies the appropriate community agencies, attending physician and the residents legal representative. Review of R2's Face Sheet revealed the facility admitted R2 on 09/13/22, with diagnoses including but not limited to: chronic obstructive pulmonary disease, vascular dementia, Alzheimer's Disease, and major depressive disorder. Review of R2's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/18/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating R2 had severe cognitive impairment. Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to: vascular dementia, osteoarthritis of the knee, major depressive disorder, and Atherosclerotic heart disease. Review of R3's Admission MDS with an ARD of 06/19/24, revealed R3 had a BIMS score of 6 out of 15, indicating R3 was severely cognitively impaired. Review of Registered Nurse (RN) written statement dated 08/11/24 at approximately 9:00 PM, revealed R2 and R3 were let out the back door of the facility by the RN on duty, along with other smokers, with no escort or supervision. The RN's written statement stated, They [R2 and R3] verbalized attention to smoke and were last visualized at 2100. Residents returned at approximately 2145. Record review of R2's progress notes did not record anything related to the elopement. Additionally, there was no notification to the Responsible Party. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R3's progress notes did not record anything related to the elopement. Additionally, there was no notification to the Responsible Party. During an interview on 08/13/24 at 11:32 AM, the Administrator stated, I arrived here about 9:40 PM after I got a call from the ADON [Assistant Director of Nursing]. She reported to me that [R2 and R3] were missing, that they had not seen them. I asked if they searched that whole building. I was told no. I instructed her to tell them to search everywhere. They were located about a mile down the road. I drove down to where they were located to be sure of the distance. During an interview on 08/13/24 at 2:25 PM, R2's daughter stated, The only time they ever tell me stuff that's going on, is in the care plan meeting. I'm not aware of this situation, of her leaving the facility and walking down the street. This really ticks me off so bad. They ain't told me nothing. Whenever I call, they tell me, well so and so is out of the office, you'll have to call back. Mama's got Alzheimer's, they need to tell me. During an interview on 08/13/24 at 2:38 PM, R3's Guardian (court appointed) stated, I am the first point of contact for [R3]. I work for an advocacy group. I am not aware she got out and was walking down the street at night. I've not been notified at all. During an interview on 08/13/24 at 4:00 PM, the Administrator stated, For investigations regarding elopement we start the investigation as soon as possible. I don't call the Responsible Party, the nurses usually make that call, not me. During the investigation period, I will ask if someone notified the Responsible Party. There are times when I may have forgotten to give the information. The Administrator confirmed there was no documentation in R2's or R3's record that the responsible party had been notified.

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NAME OF PROVIDER OR SUPPLIER Lake Emory Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Blackstock Road Inman, SC 29349	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on interview, record review, and review of facility policy, the facility failed to ensure Residents (R)2 and R3 were free from neglect, which resulted in R2 and R3 successfully eloping from the facility, for 2 of 6 residents reviewed for neglect. On 08/13/24 at 6:31, PM, the Administrator was notified that the failure to properly supervise two residents, resulting in the two residents successfully eloping from the facility, constituted Immediate Jeopardy (IJ) at F600. On 08/14/24 at 12:52 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 08/11/24. The IJ was related to 42 CFR 483.25 - Freedom from Abuse, Neglect, and Exploitation. On 08/14/24, the facility provided an acceptable IJ Removal Plan. On 08/14/24, the survey team, validated the facility's corrective actions and determined the facility did their due diligence in addressing the noncompliance at F600. The IJ is considered at Past Noncompliance as of 08/12/24. An extended survey was conducted in conjunction with the Complaint Survey for noncompliance at F600, constituting substandard quality of care. Findings include: Review of the facility's undated policy titled Abuse, Neglect, Exploitation, or Mistreatment documented, The facility's Leadership prohibits neglect, mental, physical and or verbal abuse . Component IV: Identification . 2. Neglect is the failure to provide goods and services or treatment and care necessary to avoid physical harm, mental anguish, or mental illness. Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease, vascular dementia, Alzheimer's Disease, and major depressive disorder. Review of R2's unspecified Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating R2 was severely cognitively impaired. Under the section behaviors, it recorded R2 as wandering daily. Review of R2's Elopement assessment dated [DATE], indicated R2 was not oriented to her surroundings, and she is confused. Additionally, R2 has a history of wandering and requires supervision, intervention, and wander guard. Review of R2's Physician Orders revealed an order dated 11/22/22, which revealed to have a wander guard on at all times, check function and placement every shift. Review of R2's Care Plan dated 06/18/24, revealed R2 was an elopement risk, requiring wander guard on wrist and will wander safely within the facility with no elopement attempts. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to, vascular dementia, osteoarthritis of the knee, major depressive disorder, and Atherosclerotic heart disease. Review of R3's Admission MDS with an ARD of 09/20/22, revealed R3 had a BIMS score of 6 out of 15, indicating R3 was severely cognitively impaired. Review of R3's Elopement assessment dated [DATE], revealed a diagnosis of vascular dementia, not oriented to place or time, has a history of wandering and states R3 does not have a diagnosis that requires supervision. The intervention listed was a wander guard. Review of R3's Physician Orders dated 09/14/22, revealed an order to monitor for function and placement of wander guard every shift. Review of Spartanburg Weather for the date of 08/11/24, recorded a high temperature of 87 degrees Fahrenheit and a low temperature of 71 degrees Fahrenheit with no precipitation. Review of a statement provided by Registered Nurse (RN) on 08/11/24 at approximately 9:00 PM, revealed R2 and R3 were let out the back door by the RN, on duty along, with other smokers with no escort or supervision. The RN's written statement reported, . [R2 and R3] verbalized attention to smoke and were last visualized at 2100 . Residents returned at approximately 2145. During an interview on 08/13/24 at 10:45 AM, the Assistant Director of Nursing (ADON) stated, I got a call from a nurse at the facility around 9:03 PM on 08/11/24, to report two residents were missing from Unit 2 and she couldn't find the nurse. She couldn't give me much information, so I got in my car and headed to the building. The [RN] called me to tell me they were missing as I was on the phone with 3 CNA's [Certified Nursing Assistants] on speaker, who were out looking for them. I heard the CNA say, Lets follow EMS as they passed the facility. They did and said they had found the two residents down [NAME] Road. I passed the facility and went there. I spoke to EMS. They said the residents were ok and will monitor their vitals, so I returned to the facility to do a head count, using the census, everybody was there. EMS brought the residents back about 15 minutes later. They were gone for approximately an hour. The sidewalk terminates so they either walked on grass or the road. During an interview on 08/13/24 at 11:32 AM, the Administrator stated, I arrived here about 9:40 PM, after I got a call from the ADON. She reported to me that [R2 and R3] were missing, that they had not seen them. I asked if they searched that whole building. I was told no. I instructed her to tell them to search everywhere. They were located about a mile down the road. I drove down to where they were located to be sure of the distance. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/13/24 at 12:10 PM, Certified Nurse Assistant (CNA)1, who was assigned to both residents, stated, I answered the doorbell, I thought it was my pizza. But it was two residents who were returning from outside and told me they saw two ladies outside. I immediately went to the hall I was working on, they were not there. I went to the nurse. He was from agency. He said, I let two ladies out of this door a little while ago, that was about 8:30 PM - 8:45 PM. I figured I'd let them out to smoke and they'd be right back. He said they looked like they could be allowed outside, they looked competent. I said what two ladies, one with a walker and one with sunglasses on and he said yes. I knew that was them. After that, I asked are they still out there. I walked outside and I didn't see them and started walking around the building. I grabbed a CNA from another hall and the hospitality aid who was out in the courtyard with the smokers. I went back to the nurse and told him I couldn't find those residents outside. I said I think we need to call a code or call someone. He said, I am not calling anybody until you check everybody in the facility. We then did that. I went back and informed him they were not there. The nurse on the other unit called the ADON and reported it to her. That's when the ADON said she was coming in. We went back outside and looked for the two ladies. There's another facility to the left of the building and two CNA's went that way to see if they were there. Then I saw an EMS truck go by, we followed them. I went with another CNA and followed the fire truck, ambulance and cop car. We followed them about a mile and a half or so. We saw them pulled over and the two residents were there. EMS said they are fine, it's just hot. We are going to take their vitals. The officer said someone had called it in, they drove by and saw them. It was about 1.5 - 2 miles away. [R2] was wearing a tee shirt and capri's with tennis shoes, [R3] had on a long sleeve shirt and pants with her ballerina slipper like shoes, she was very hot, sweating so bad. Her heart rate was 180, that is what EMS said. During an interview on 08/13/24 at 1:18 PM, CNA2 stated, I worked on Sunday on the 3 - 11 shift. I was working on station 1. One of the residents came to me and told me two of the ladies got out. I went outside to scope and see. I saw some other CNAs out there. We told the nurses. I got in my car and drove onto [NAME] Road to the right and didn't see them, so I went the opposite way and didn't see them. I guess I didn't go far enough because I didn't see them. During an interview on 08/13/24 at 2:04 PM, R7 stated, We just got back from the store. We seen [R2 and R3] coming out the back door. They walked the property. They went toward the entrance and never came in. I went to the street, and I didn't see them. I rang the doorbell and the nursing assistant answered. We told her about the two ladies we saw. She went to their rooms and didn't see them. I went to the nurse to tell him. I didn't see who let them out. On 08/14/24, the facility provided an acceptable IJ Removal Plan, which included the following: Residents #2 and #3 returned to the facility on [DATE]. Residents were assessed by the Assistant Director of Nursing on 8/11/24. No injuries identified . Social Services assessed residents for emotional distress on 8/13/24 and referrals made as indicated . Agency Nurse was sent home on 08/11/24 and agency notified for this nurse to not return to this facility. Elopement risk Assessments were completed on 8/12/24 . Those residents identified at risk had interventions initiated and care plan updated by 8/13/24. Facility staff were reeducated on Elopement Policy by the Director of Nursing/Designee on 8/12/24 . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility staff were reeducated on Abuse, Neglect, & Misappropriation by the Administrator/Designee on 8/14/24 . Facility staff not receiving this education by the target date will receive prior to their next scheduled shift. Agency staff will be educated on the Elopement Policy and Abuse, Neglect & Misappropriation policy prior to their first assignment . An elopement drill will be completed by 8/14/24 on each shift . Director of nursing/Designee will interview a minimum of 5 staff members per week for 4 weeks to validate transfer of knowledge. The Administrator/Designee will interview a minimum of 5 residents per week for 4 weeks to validate residents feel safe and have no care concerns. The Director of Nursing/Designee will observe care and interactions of staff members with 3 residents per week for 4 weeks to validate residents feel safe and there is no care concerns. Any identified issues will be addressed at time of discovery. Ad Hoc QAPI was held on 8/14/24 to review the contents of this plan. The Medical Director was notified on 8/14/24 of the immediate Jeopardy and the contents of this plan. AOC date: 8/15/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48835 Based on interviews, record review and review of facility policy, the facility failed to provide appropriate supervision to prevent Resident (R)2, and (R)3's elopement from the facility. On 08/13/24 at 6:31 PM, the Administrator was notified that the failure to properly supervise two residents, resulting in the two residents successfully eloping from the facility, constituted Immediate Jeopardy (IJ) at F689. On 08/13/24 at 6:31 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 08/11/24. The IJ was related to 42 CFR 483.25 - Free of Accident Hazards/Supervision. On 08/14/24, the facility provided an acceptable IJ Removal Plan. On 08/14/24, the survey team, validated the facility's corrective actions and determined the facility did their due diligence in addressing the noncompliance at F689. The IJ is considered at Past Noncompliance as of 08/12/24. An extended survey was conducted in conjunction with the Complaint Survey for noncompliance at F689, constituting substandard quality of care. Findings include: Review of the facility policy titled Elopement dated 11/01/17, stated, To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. The facility will determine a signal code, e.g. Code [NAME] to designate a missing patient/resident. Once is it determined that a patient/resident is missing, all employees are notified immediately by paging overhead, and it was blank but states, insert code name. Review of the facility policy titled Accident/Incident Reporting - Patient/Resident stated, An accident is an unexpected, unintended event that can result in bodily injury. Review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE], with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease, vascular dementia, Alzheimer's Disease, and major depressive disorder. Review of R2's unspecified Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/24, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating R2 was severely cognitively impaired. Under the section behaviors, it recorded R2 as wandering daily. Review of R2's Elopement assessment dated [DATE], indicated R2 was not oriented to her surroundings, and she is confused. Additionally, R2 has a history of wandering and requires supervision, intervention, and wander guard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R2's Physician Orders revealed an order dated 11/22/22, which revealed to have a wander guard on at all times, check function and placement every shift. Review of R2's Care Plan dated 06/18/24, revealed R2 was an elopement risk, requiring wander guard on wrist and will wander safely within the facility with no elopement attempts. Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to, vascular dementia, osteoarthritis of the knee, major depressive disorder, and Atherosclerotic heart disease. Review of R3's Admission MDS with an ARD of 09/20/22, revealed R3 had a BIMS score of 6 out of 15, indicating R3 was severely cognitively impaired. Review of R3's Elopement assessment dated [DATE], revealed a diagnosis of vascular dementia, not oriented to place or time, has a history of wandering and states R3 does not have a diagnosis that requires supervision. The intervention listed was a wander guard. Review of R3's Physician Orders dated 09/14/22, revealed an order to monitor for function and placement of wander guard every shift. Review of Spartanburg Weather for the date of 08/11/24, recorded a high temperature of 87 degrees Fahrenheit and a low temperature of 71 degrees Fahrenheit with no precipitation. Review of a statement provided by Registered Nurse (RN) on 08/11/24 at approximately 9:00 PM, revealed R2 and R3 were let out the back door by the RN, on duty along, with other smokers with no escort or supervision. The RN's written statement reported, . [R2 and R3] verbalized attention to smoke and were last visualized at 2100 . Residents returned at approximately 2145. During an interview on 08/13/24 at 10:45 AM, the Assistant Director of Nursing (ADON) stated, I got a call from a nurse at the facility around 9:03 PM on 08/11/24, to report two residents were missing from Unit 2 and she couldn't find the nurse. She couldn't give me much information, so I got in my car and headed to the building. The [RN] called me to tell me they were missing as I was on the phone with 3 CNA's [Certified Nursing Assistants] on speaker, who were out looking for them. I heard the CNA say, Lets follow EMS as they passed the facility. They did and said they had found the two residents down [NAME] Road. I passed the facility and went there. I spoke to EMS. They said the residents were ok and will monitor their vitals, so I returned to the facility to do a head count, using the census, everybody was there. EMS brought the residents back about 15 minutes later. They were gone for approximately an hour. The sidewalk terminates so they either walked on grass or the road. During an interview on 08/13/24 at 11:32 AM, the Administrator stated, I arrived here about 9:40 PM, after I got a call from the ADON. She reported to me that [R2 and R3] were missing, that they had not seen them. I asked if they searched that whole building. I was told no. I instructed her to tell them to search everywhere. They were located about a mile down the road. I drove down to where they were located to be sure of the distance. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/13/24 at 12:10 PM, Certified Nurse Assistant (CNA)1, who was assigned to both residents, stated, I answered the doorbell, I thought it was my pizza. But it was two residents who were returning from outside and told me they saw two ladies outside. I immediately went to the hall I was working on, they were not there. I went to the nurse. He was from agency. He said, I let two ladies out of this door a little while ago, that was about 8:30 PM - 8:45 PM. I figured I'd let them out to smoke and they'd be right back. I asked are they still out there. I walked outside and I didn't see them and started walking around the building. I grabbed a CNA from another hall and the hospitality aid who was out in the courtyard with the smokers. I went back to the nurse and told him I couldn't find those residents outside. I said I think we need to call a code or call someone. He said, I am not calling anybody until you check everybody in the facility. We then did that. I went back and informed him they were not there. The nurse on the other unit called the ADON and reported it to her. That's when the ADON said she was coming in. We went back outside and looked for the two ladies. There's another facility to the left of the building and two CNA's went that way to see if they were there. Then I saw an EMS truck go by, we followed them. I went with another CNA and followed the fire truck, ambulance and cop car. We followed them about a mile and a half or so. We saw them pulled over and the two residents were there. EMS said they are fine, it's just hot. We are going to take their vitals. The officer said someone had called it in, they drove by and saw them. It was about 1.5 - 2 miles away. [R2] was wearing a tee shirt and capri's with tennis shoes, [R3] had on a long sleeve shirt and pants with her ballerina slipper like shoes, she was very hot, sweating so bad. Her heart rate was 180, that is what EMS said. During an interview on 08/13/24 at 1:18 PM, CNA2 stated, I worked on Sunday on the 3 - 11 shift. I was working on station 1. One of the residents came to me and told me two of the ladies got out. I went outside to scope and see. I saw some other CNAs out there. We told the nurses. I got in my car and drove onto [NAME] Road to the right and didn't see them, so I went the opposite way and didn't see them. I guess I didn't go far enough because I didn't see them. During an interview on 08/13/24 at 2:04 PM, R7 stated, We just got back from the store. We seen [R2 and R3] coming out the back door. They walked the property. They went toward the entrance and never came in. I went to the street, and I didn't see them. I rang the doorbell and the nursing assistant answered. We told her about the two ladies we saw. She went to their rooms and didn't see them. I went to the nurse to tell him. I didn't see who let them out. On 08/14/24, the facility provided an acceptable IJ Removal Plan, which included the following: Residents #2 and #3 returned to the facility on [DATE]. Residents were assessed by the Assistant Director of Nursing on 8/11/24. No injuries identified . Social Services assessed residents for emotional distress on 8/13/24 and referrals made as indicated . Agency Nurse was sent home on 08/11/24 and agency notified for this nurse to not return to this facility. Elopement risk Assessments were completed on 8/12/24 . Those residents identified at risk had interventions initiated and care plan updated by 8/13/24. Facility staff were reeducated on Elopement Policy by the Director of Nursing/Designee on 8/12/24 . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility staff not receiving this education by the target date will receive prior to their next scheduled shift. Agency staff will be educated on the Elopement Policy and Abuse, Neglect & Misappropriation policy prior to their first assignment . An elopement drill will be completed by 8/14/24 on each shift . Director of nursing/Designee will interview a minimum of 5 staff members per week for 4 weeks to validate transfer of knowledge. Ad Hoc QAPI was held on 8/13/24 to review the contents of this plan. The Medical Director was notified on 8/13/24 of the immediate Jeopardy and the contents of this plan. AOC date: 8/14/24