

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/14/2026
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 13390 N ILLINOIS STREET, CARMEL, , 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 471271. Intake 471271- State deficiencies related to the allegations are cited at R52, R217, and R349. Survey dates: September 11 and 14, 2026 Facility number: 013297 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 17, 2026.	R 0000	POC completion		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Resident B was discharged from	09/18/2026	

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

(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure residents with a diagnosis of dementia (Residents C and D) were free of physical abuse from another resident with a diagnosis of violent behaviors (Resident B) for 3 of 3 residents reviewed for abuse. This deficient practice resulted in Resident C being attacked while in bed by Resident B and Resident D being struck across the face, shoulder, and shook by Resident B. Findings include: 1. During an observation, on 9/11/26 at 9:36 a.m., Resident D was wandering the locked Memory Care unit hallway singing and whistling. During an interview, on 9/11/26 at 2:05 p.m., Resident D's Power of Attorney (POA) indicated Resident D had a diagnosis of vascular dementia, would constantly wander around	the community to a facility more equipped to navigate the care needs and behaviors. how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. DON or designated person will review diagnosis or run report to audit residents with violent behaviors diagnosis or similar diagnosis that could lead to violent behaviors. Those residents identified will have service plan reviewed and updated, medications reviewed and behavioral health services put in place as supportive care. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. An audit tool was created for DON or designated person to follow to track the potential violent or aggressive residents in the community and to ensure steps are taken to prevent similar incidents from occurring. Describe how the corrective action(s) will be monitored to	
---	--	--

the unit and could be found by listening for someone singing. The facility had contacted the POA in June 2026 and reported Resident D was sitting at a table in the dining room when another resident had walked up to Resident D, yelling at her to stop singing, and hit her on the arm.

The clinical record for Resident D was reviewed on 9/11/26 at 12:38 p.m. The diagnoses included, but were not limited to, dementia and falls.

A progress note, dated 6/24/26 at 2:05 p.m., indicated Resident D was finishing lunch when another resident (Resident B) approached her, and struck the left side of her face with an open hand, shook her by the shoulders, and struck her again on the shoulder with an open hand.

2. A facility reported incident indicated, on 8/4/26 at 10:30 p.m., staff were attending to another resident when they heard a resident yelling. Upon entering Resident C's room, staff observed Resident B with her hands around Resident C's neck. Resident C was observed with several scratches on her neck area and a skin tear on her forearm. The care plans would be reviewed and updated.

During an interview, on 9/11/26

ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Monitoring should be on-going, all identified residents with confirmed diagnosis to potentially become violent, or residents with violence in their past will require on going monitoring. Any new residents will be screened on admission or during assessment period to determine if they are appropriate for the community. Reviews shall take place with quarterly assessments and as incidents occur. Audit will be completed by DON and or designated clinical staff by 10/31/2026.

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

	at 9:42 a.m., Qualified Medication Aide (QMA) 2 indicated she was not on duty during the incident but was informed during shift change report Resident B attacked Resident C during the night shift. During an observation and interview, on 9/11/26 at 9:43 a.m., Resident C's door was locked, and the door had a push button keypad lock. Assistance was requested from the nurse to enter the resident's room; Resident C was lying in bed. Resident C indicated one night while lying in bed asleep, she had woken up and opened her eyes to find another resident (Resident B) in her room. She asked Resident B to get out of her room and then Resident B attacked her. Resident B had scratched her neck and her left arm. Resident C started screaming until staff members came in and removed Resident B from her room. Resident C explained the incident was a very scary ordeal and now she had a lock on her door. During an interview, on 9/14/26 at 8:37 a.m., Resident C's POA 1 indicated she had missed a phone call from her mother at approximately 10:45 p.m., on 8/4/26. Shortly thereafter, she received another call from her sister, Resident C's other POA			
--	--	--	--	--

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

	(POA 2) who explained she received a frantic phone call from Resident C saying someone attacked her while she was in bed. POA 1 visited the facility the next day and was told the facility had placed a keypad lock on Resident C's door. Resident C had a bandage on her neck and arm and was still frightened about the attack. The facility had placed an order for an oral and topical antibiotic to prevent infection from dirty fingernails breaking open the skin. During an interview, on 9/14/26 at 9:37 a.m., Resident C's POA 2 indicated, on 8/4/26 at approximately 10:45 p.m., Resident C called her and was extremely upset saying someone had come into her room, attacked her, and she had cuts and scrapes on her neck and arm. POA 2 attempted to call the facility but had to leave a message. POA 2 attempted a second call immediately after leaving the message but was unable to get an answer. The QMA returned the call and reported another resident had entered Resident C's room and attacked her. POA 2 told the QMA about the phone call from Resident C, that Resident C was still very upset, and asked the QMA to please go check on Resident C again.			
--	---	--	--	--

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

	The clinical record for Resident C was reviewed on 9/11/26 at 11:26 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and insomnia. A service plan goal, dated 9/6/26, indicated Resident C would feel comfortable in their environment. A progress note, dated 8/6/26, indicated the physician had ordered a topical ointment to be applied twice a day, to Resident C's neck and left hand and to keep the areas covered with a non-stick bandage. There was no documentation of the incident found in Resident C's electronic health record. 3. During an interview, on 9/11/26 at 1:14 p.m., Resident B's POA indicated Resident B had entered another resident's room (Resident C). When the other resident screamed, it triggered Resident B and she attacked the resident. Resident B had been verbally aggressive to a male resident in the past. Resident B's POA had not been informed of a resident-to-resident altercation in June 2026. The clinical record for Resident B was reviewed on 9/11/26 at 10:16 a.m. The diagnoses included, but were not limited to,			
--	---	--	--	--

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

violent behavior, dementia, and disorientation.

A service plan, dated 3/9/26, indicated Resident B could exhibit sun-downing behavior, occasional wandering with easy redirection, and routinely exhibited anxious behavior requiring staff attention.

A progress note, dated 6/5/26, indicated Resident B was discharged to an in-patient psychiatric facility for aggressive behaviors.

A progress note, dated 6/17/26, indicated Resident B returned to the facility. During the in-patient psychiatric stay, Resident B displayed behaviors which required intervention of an intramuscular injection on 6/13/26.

A progress note, dated 6/24/26 at 2:09 p.m., indicated Resident B approached Resident D at the community dining room table and stuck Resident D on the left side of the face with her right open hand. Resident B then grabbed Resident D's shoulders and began shaking her and then struck Resident D again on the left shoulder with an open hand.

A progress note, dated 8/4/26 at 10:45 p.m., indicated staff heard yelling and found Resident B standing over Resident C, who was lying in bed, with her hands

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

around Resident C's neck. Resident C had open bleeding scratches to her neck and forearm.

During an interview, on 9/11/26 at 9:55 a.m., the Executive Director (ED) indicated Resident B wandered the memory care unit and could become agitated but had never been aggressive towards another resident in the past.

During an interview, on 9/14/26 at 10:25 a.m., the Wellness Director indicated the nurse on duty had informed her they found Resident B scratching Resident C's neck and arm. Resident B had a history of outbursts prior to being admitted into the facility involving her family. Since moving to the memory care unit, her aggressive behaviors had increased in frequency and intensity. A few months ago (June 2026), Resident D was sitting in the dining room singing, when Resident B yelled at her to stop singing and placed her hand on Resident D's cheek in a non-forceful manor.

A current facility policy, titled "Resident-to-Resident Contact," last revised 12/20/21 and received from the ED on 9/11/26 at 9:55 a.m., indicated "...The purpose of the

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

	Resident-to-Resident Contact Policy is to ensure the safety of all individuals within the community...All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Wellness Leader and Executive Director...If two residents are involved in an altercation, staff will...separate the residents, and institute measures to calm the situation...Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation...Notify each residence representative and attending physician of the incident...If after carefully evaluating the situation, it is determined that any of the residents involved may need a change in their care needs, a care conference and evaluation should be initiated...." A current facility policy, titled "Abuse, Neglect, or Exploitation," last revised on 6/7/23 and received from the ED on 9/11/26 at 9:55 a.m., indicated "...Abuse-Harm or threatened harm to an adult's health or welfare caused by another person...Abuse, neglect, or exploitation of any resident will not be tolerated...Community will address situations in which			
--	---	--	--	--

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

abuse, neglect, or exploitation are more likely to occur. This includes, but is not limited to, the following...Encouragement of staff to monitor residents routinely...Care planning of residents with special needs and/ or behavior expressions that might lead to conflict, or neglect. Examples of special needs and/or behavior expressions may include refusal or resistance to care, entering other residents' rooms uninvited, exit seeking, self-injury, and residents with communication difficulties...."

A current facility policy, titled "Resident Rights," last updated 3/15/17 and received from the ED on 9/11/26 at 9:55 a.m., indicated "...You have the right to a dignified existence...You have a right to be treated with respect and dignity, including...the right to be free from abuse, neglect...You have the right to a safe, clean, comfortable and home like environment, including but not limited to receiving treatment and supports for daily living safely...."

This citation relates to Intake 471271.

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	Describe what the facility did to correct the deficient practice for each client cited in the	09/18/2026
--------	---	--------	---	------------

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

(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and	deficiency. Audit tool was created to aide with updating and reviewing Service Plans for Memory care residents in the community. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. DON or designated person will audit all service plans for residents on memory care ,those with violent behaviors diagnosis or similar diagnosis that could lead to violent behaviors will have appropriate service plans in place. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Audit tool to be implemented for DON or clinical member to follow to review and update memory care Service Plans. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	
---	--	--

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

documentation of the services to be provided.

Based on interview and record review, the facility failed to ensure a resident's service plan was updated to reflect changes in the resident's behavioral care needs after exhibiting verbal aggression and physical violence toward other residents, a new diagnosis of violent behavior was added, and interventions were initiated following the resident's increased aggressive and violent behaviors for 1 of 3 residents reviewed for behaviors. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 9/11/26 at 10:16 a.m. The diagnoses included, but were not limited to, violent behavior, dementia, and disorientation.

A service plan, dated 3/9/26, indicated Resident B would exhibit sun-downing behavior, occasional wandering with easy redirection, and routinely exhibited anxious behavior which required staff attention.

A progress note, dated 4/14/26, indicated Resident B had become physically violent with a staff member and verbally aggressive with another

into place.

Monitoring should be on-going, DON or designated clinical member, will complete audit of service plans and ensure they are accurate and up to date. Service Plans will be updated with each new incident or change the resident has. Audit of Service Plans will be completed for Memory Care residents by DON or clinical members by 10/31/2026, utilizing new audit tool.

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

resident.

Resident B received a new diagnosis of violent behavior on 5/14/26.

A progress note, dated 5/14/26, indicated there were multiple complaints of Resident B being physically and verbally aggressive to an outside vendor when the resident was being redirected from exit seeking. Resident B had inflicted scratches on the vendor's neck. The night shift QMA (Qualified Medication Aide) reported at around 2:00 a.m., Resident B was witnessed yelling very intensively at another resident.

A psychiatric visit note, dated 6/5/26, indicated Resident B was seen at the request of the facility staff for worsening aggressive behaviors. Since Resident B's admission to the memory care unit, the resident had exhibited intermittent episodes of irritability and aggression with reported escalation in frequency and severity of the behaviors. Resident B had become verbally and physically aggressive toward residents and staff and had created significant safety concerns within the memory care unit. The resident was involved in a recent resident-to-resident altercation in which Resident B shoved and

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

	struck another resident. The facility staff described Resident B as highly irritable, easily frustrated, and quick to react when upset or overstimulated. Resident B would benefit from in-patient psychiatric evaluation and behavioral stabilization. The staff were to maintain behavioral interventions and redirection techniques. Resident B's service plan did not include behavioral interventions or redirection techniques. A progress note, dated 6/5/26, indicated Resident B was discharged to an in-patient psychiatric facility for an aggressive behavior evaluation. The psychiatric hospital documents, dated 6/11/26 through 6/17/26, indicated Resident B had been exhibiting increasingly violent behaviors over the past few months, injuring other residents according to the memory care facility. During her in-patient stay, Resident B presented with agitation, physical aggression, paranoid thoughts, was not easily redirected, was observed on one occasion standing over her roommate in a threatening or paranoid manner while the roommate was in bed, and on multiple occasions had required soft restraints and medication			
--	---	--	--	--

injections for physical violence. Resident B's medication regimen was changed, and the resident would be discharged back to the memory care facility.

A progress note, dated 6/17/26, indicated Resident B returned to the facility.

An updated service plan after readmission to the facility could not be located in the electronic health record.

A progress note, dated 6/24/26, indicated Resident B was physically violent by striking a resident on the face, shoulder, and shaking them.

A progress note, dated 8/4/26, indicated staff observed Resident B standing over another resident while the resident was in their room and in bed, with her hands (Resident B) around the other resident's neck and leaving scratches on the other resident's neck and arm.

During an interview, on 9/11/26 at 1:14 p.m., Resident B's Power of Attorney indicated Resident B had been having worsening behaviors since moving to the memory care unit in March 2026 and the facility had sent her for a psychiatric evaluation and behavioral management. He had not attended a care plan meeting or

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

signed an updated service plan outlining Resident B's behavioral care needs.

During an interview, on 9/14/26 at 10:25 a.m., the Wellness Director indicated Resident B had a history of outbursts with family prior to being admitted to the facility. Resident B had a previous psychiatric hospitalization and had returned to the facility with improved behaviors, but the aggression returned. Resident B's behaviors would warrant the need for an updated and signed service plan. Resident B's service plan had not been updated, and a care plan meeting had not been held. Resident B's Power of Attorney was aware of her needs related to behaviors. The facility had interventions in place. Staff knew how to monitor triggers and wandering residents and to keep Resident B occupied and active.

The electronic health record lacked documentation to indicate the service plan was updated to include violent behaviors, verbal aggression, interventions, or mental health services the resident would need for behavioral management after a new diagnosis of violent behavior was given, upon readmission to the memory care unit from an

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

	in-patient psychiatric hospitalization, or after two separate resident-to-resident altercations. A current facility policy, titled "Resident Evaluation and Service Plan," last revised 8/28/26 and received from the Wellness Director, indicated "...The purpose of the Service Plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences...Evaluations are completed...At move in...Every six (6) months unless required by state licensing to be completed more frequently...With change in condition (such as but not limited to: return from hospital)...Service plans are completed by the Wellness leader or designee with input from one or more of the following...resident, family or responsible party, healthcare provider, community caregivers/life enrichment team members, any additional provider in coordination for resident care...the individual completing and/or reviewing the Service plan shall sign the Service plan. The resident and/or responsible party shall also sign the Service plan after reviewing the Service plan...A Service plan is developed according to the needs and			
--	--	--	--	--

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

	preferences of a resident identified through the evaluation process...the Service plan is reviewed and updated at least annually or according to state licensing requirements and when a residence needs or preferences change...." This citation relates to Intake 471271.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.	R 0349	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Audit tool was created as a checklist of what to do in the event of a resident to resident altercation. Resident B was discharged from the community to a facility more equipped with meeting the needs of said resident. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. An audit tool or checklist was created for DON and other clinical members to use to guide with steps of what to do in the event of a resident to resident altercation. This will allow DON	09/18/2026

Based on interview and record review, the facility failed to ensure resident records contained accurate documentation regarding specialized services, a resident-to-resident altercation (Resident C), and accurate wellness evaluations (Resident D), for 2 of 2 residents records reviewed for documentation.

Findings include:

1. The clinical record for Resident C was reviewed on 9/11/26 at 11:26 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and insomnia.

a. A physician's order, dated 8/19/24, indicated Resident C was admitted to Hospice services.

A semi-annual wellness evaluation, dated 2/27/26 and signed by the Wellness Director on 3/6/26, indicated Resident C was receiving Hospice services, incontinence care products would be provided by Hospice, and Hospice would perform all bathing tasks with facility staff ensuring the tasks were completed.

On 9/11/26 at 11:50 a.m., the surveyor requested Resident C's Hospice binder.

During an interview, on 9/11/25

and or ED a documented timeline of notifications and documentation, and allow for accountability for those involved.

Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.

Audit tool to be implemented for DON or clinical member to follow ensure correct steps are followed.

Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

ED and or DON will be responsible for following up with staff and audit tool to ensure all proper steps are followed with each incident, ED or DON will keep a binder with incident tools in them once they are complete.

at 12:02 p.m., the Wellness Director indicated Resident C was no longer appropriate for Hospice services and had been discharge from Hospice on 6/3/25 and the Hospice order should have been discontinued.

b. A facility reported incident indicated, on 8/4/26 at 10:30 p.m., staff heard another resident yelling. Upon entering Resident C's room, staff observed another resident with her hands around Resident C's neck. Resident C was observed with several scratches on her neck area and skin tear on her forearm.

Resident C's electronic health record lacked documentation of the resident-to-resident altercation, assessment of injuries, notification to the resident representative, notification to the physician, and notification to the Wellness Director.

2. The clinical record for Resident D was reviewed on 9/11/26 at 12:38 p.m. The diagnoses included, but were not limited to, dementia and falls.

A physician's history and physical document, dated 7/22/25, indicated Resident D had a diagnosis of dementia.

A service plan, dated 7/18/25,

indicated Resident D required assistance with redirection due to occasional confusion, deficits in judgment, wandering or exit seeking.

Resident D's most recent wellness evaluation, dated 8/4/26 and signed by the Wellness Director on 8/18/26, indicated Resident D did not have a current diagnosis or past medical history of dementia.

During an interview, on 9/11/24 at 2:05 p.m., Resident D's Power of Attorney indicated Resident D was diagnosed with vascular dementia at a previous health care facility prior to being admitted to the facility she was currently residing.

During an interview, on 9/14/26 at 11:57 a.m., the Wellness Director indicated the evening and night shift were staffed with QMAs (Qualified Medication Aides) with a nurse always available on call. Per company policy, QMA's were not to document in a resident's progress notes or the evaluation tab in the record. QMAs could document in the communication binder, and a nurse would input the information into the resident's record. The facility was aware the consistency of QMA documentation in the binder was insufficient. The facility did not have a policy regarding the accuracy of

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

resident records, and the company had not completed the policy regarding the QMA's being prohibited to document in the record.

A current facility document, titled "Qualified Medication Aide Scope of Practice," undated and received from the Wellness Director on 9/14/26 at 12:01 p.m., indicated "...The following tasks are within the scope of practice for the QMA unless prohibited by facility policy...Document in the clinical record the QMA observations, including what the QMA sees, hears, or smells and document what is reported to the QMA by the resident...."

This citation relates to Intake 471271.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE Marshall Bowman

TITLE HFA

(X6) DATE 09/27/2026