AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/07/2023			
	NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY		700	EET ADDRESS, CITY, STATE, ZIP COD E 21ST AVE RY, IN 46407	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE
F 0000 Bldg. 00						
	This visit was for the IN00396194 and IN	he Investigation of Complaints N00397311.	F 0000			
	Revisit (PSR) to the 28, 2022 to the Reco	onjunction with a Post Survey e PSR completed on November certification and State Licensure on October 6, 2022.				
	Federal/State defic	6194 - Substantiated. iencies related to the d at F609 and F610.				
	-	7311 - Substantiated. No l to the allegations are cited.				
	Survey date: Febru	nary 7, 2023				
	Facility number: 000368 Provider number: 155845 AIM number: 100275220					
	Census Bed Type: SNF/NF: 21 Total: 21					
	Census Payor Type Medicaid: 20 Other: 1 Total: 21	::				
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.				
	Quality review con	npleted on 2/9/23.				
F 0609 SS=D	483.12(b)(5)(i)(A) Reporting of Allec					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						

(X6) DATE

RAENITA DUMAS RNDON 02/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y2ZE11 Facility ID: 000368 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155845	B. WING 02/07/2023			
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			700 E	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
Bldg. 00	§483.12(c) In resp abuse, neglect, ex the facility must: §483.12(c)(1) Ens violations involving exploitation or mis injuries of unknow misappropriation or reported immediat hours after the alle events that cause or result in serious than 24 hours if th	conse to allegations of exploitation, or mistreatment, our that all alleged grabuse, neglect, our treatment, including an source and of resident property, are stelly, but not later than 2 regation is made, if the the allegation involve abuse is bodily injury, or not later the events that cause the	TAG	DEFICIENCE	DATE	
	allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.					
	investigations to the her designated reposition officials in accordation including to the St 5 working days of alleged violation is corrective action in					
	failed to ensure an a physical abuse was Agency for 1 of 2 al physical abuse revie	view and interview, the facility allegation of verbal and reported to the State Survey llegations of verbal and ewed. (Resident C)	F 0609	F609 Corrective Action(s) for Residents Affected by the Deficient Practice A report regarding an allegation staff to resident abuse was		
	Finding includes: Interview with the I	Director of Nursing (DON) on		submitted to IDOH on 2/07/23 7:55P.M. Resident C has significant cognitive impairment		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y2ZE11

Facility ID: 000368

If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/07/2023 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2/7/23 at 10:00 a.m., indicated there had been no and per interview on 2/08/23, allegations of abuse since November 2022 that however she was able to reaffirm were reported to her. the same response during the investigation, "I love him he cleans During the previous survey visit entrance on my room every day," there was no 11/28/22, there were also said to be no allegations hesitation with her response as of abuse reported to administration. she hugged the employee during her response. During a confidential interview during the survey on 2/7/23, it was voiced that Resident C had Corrective Action(s) for Other reported an allegation of abuse by a staff member. **Residents Potentially Affected** The resident indicated that Employee 1 had All residents have the potential to "shoved" her out of her room and told her to "get be affected by this deficient the f...k out." Further confidential interview practice. Administrative staff have indicated the DON was immediately notified of the met privately with all interviewable allegation. She indicated to write up what residents and state they have not happened and slip the notice under her door and personally experienced any staff she would take care of it, but not to document in to resident abuse nor have they the resident's chart. witnessed any such actions since 2/07/23. Administrative staff have The record for Resident C was reviewed on 2/7/23 met privately with all current staff at 2:19 p.m. Diagnoses included, but were not members, and no one has limited to, dementia with behavior disturbance and witnessed any staff to resident bipolar disorder. abuse or mistreatment since 2/07/23. The Significant Change Minimum Data Set (MDS) assessment, dated 1/4/23, indicated the resident Measures to Ensure the was cognitively impaired for daily decision **Deficient Practice Does Not** making. All staff have been re-educated on Nurses' Notes, dated 11/2022 through 2/7/23, the need to immediately report to indicated there was no documentation related to the Administrator and the DON the allegation of abuse. any allegations of abuse including staff to resident or resident to Interview with the DON on 2/7/23 at 4:00 p.m., resident abuse. indicated she was aware of the situation and the allegation was not substantiated based on her The Administrator and the DON investigation so she did not report the allegation were re-inserviced by nurse to the State Survey Agency. consultant and are aware of their

responsibility to report

		X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		JILDING	00		OMPLETED	
	155845		B. W	ING		02/07/	2023	
	PROVIDER OR SUPPLIER		•	700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	•		
	S LOVING CARE F SUMMARY: (EACH DEFICIEN REGULATORY OR The facility abuse p on 2/7/23 at 4:30 p.: ensure all alleged vi neglect, exploitation injuries of unknown of resident property but not later than 2 ! made, if the events involved abuse or re injury, or not later ti caused the allegatio did not result in seri Administrator of the (including the State Protective Services jurisdiction in long accordance with Sta		B. W	STREET A	S1ST AVE	Zery glect, of N illity and th ed. er for ecord e or ecie, ser for ime DOH ation	(X5) COMPLETION DATE	
					The Social Worker will meet individually with all interviewal residents and ask key questio related to their quality of life at care including staff treatment. interviews will be conducted weekly and residents rotated that all interviewable residents.	ns nd Five		

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Event ID:

Y2ZE11 Facility ID: 000368

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

PRINTED: 02/28/2023 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155845		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/07/2023
	ROVIDER OR SUPPLIE	R HEALTH FACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION PRIATE DATE
TAG	REGULATORT	Y OR LSC IDENTIFYING INFORMATION	IAU	be interviewed at least once month on-going.	
				The results of these intervies be documented and provide the Administrator at the conclusion of each week. A resident concerns identified through the interviews will addressed by administrativ with a written plan; the plan submitted to the QAPI comfor review. Further correctivactions will be developed a implemented as deemed necessary. DATE: 2/7/23 Report submitted through through the gate by D.O.N. if was never he intent to not disclose this event. Social Service has been assigned to this task monitor residents to ensure they have no complaints. 2/ 16/23 Inservice held with staff on abuse police and monitoring for allegations abuse and all abuse listed policy. Re-inservice held with chanurses on shift to shift ab monitoring form which is located with shift to shift report. Charge Nurses daily monitor abuse and have a log to complete if any allegation.	ed to Any d be e staff n will be mittee //e nd way r A to ire th all arge use
				reported. Copy of form attached.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y2ZE11

Facility ID: 000368

If continuation sheet

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CENTERS FOR	MEDICARE & MEDIC			CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO						
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED					
		155845	B. WING		02/07/2023					
	ROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)					
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION					
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE					
				2/17/23 Social Service audit a interviewable residents. Her audit included a review of resident's rights, abuse polic and any comments the residents expressed. No allegations of abuse were stated to SW. Copy of audit attached.						
F 0610 SS=D Bldg. 00	§483.12(c) In resp abuse, neglect, ex the facility must: §483.12(c)(2) Hav violations are thore §483.12(c)(3) Prev neglect, exploitation the investigation is §483.12(c)(4) Rep investigations to the her designated rep officials in accordaring to the St 5 working days of	oort the results of all ne administrator or his or oresentative and to other ance with State law, ate Survey Agency, within the incident, and if the severified appropriate								
	Based on record rev failed to ensure an a physical abuse was	riew and interview, the facility allegation of verbal and thoroughly investigated for 1 rerbal and physical abuse	F 0610	F610 - Corrective Action(s) for Residents Affected by the Deficient Practice An investigation regarding an allegation of staff to resident abuse was started on 2/07/23 immediately following submiss	02/21/2023 sion					

FORM CMS-2567(02-99) Previous Versions Obsolete

Interview with the Director of Nursing (DON) on

Event ID:

Y2ZE11

Facility ID: 000368

If

of the report to IDOH. Resident C

If continuation sheet Page 6 of 10

		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155845	A. BI		00	COMPLETED 02/07/2023	
		133043	D. W			02/01/	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
SIMMON	SIMMONS LOVING CARE HEALTH FACILITY				IN 46407		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		., indicated there had been no			has significant cognitive		
	_	e since November 2022 that			impairment and per interview		
	were reported to he	r.			2/08/23, however she was abl		
	D : a :	• •,			reaffirm the same response d	-	
		s survey visit entrance on			the investigation, "I love him h		
		re also said to be no allegations			cleans my room every day," th	iere	
	of abuse reported to	o administration.			was no hesitation with her		
	D				response as she hugged the	_	
	_	ial interview during the survey biced that Resident C had			employee during her response	э.	
	· ·				Commenting Action(c) for Other		
	reported an allegation of abuse by a staff member. The resident indicated that Employee 1 had				Corrective Action(s) for Other Residents Potentially Affects		
		Ther room and told her to "get			All residents have the potentia		
		ner confidential interview			be affected by this deficient	11 10	
		was immediately notified of the			practice. Administrative staff h	2010	
		cated to write up what			met privately with all interview		
	_	the notice under her door and			residents and all state they ha		
		e of it, but not to document in			not personally experienced ar		
	the resident's chart.				staff to resident abuse nor have	-	
					they witnessed any such actic		
	The record for Resi	ident C was reviewed on 2/7/23			since 2/07/23. Administrative		
	at 2:19 p.m. Diagn	oses included, but were not			have met privately with all cur	rent	
		a with behavior disturbance and			staff members, and no one ha		
	bipolar disorder.				witnessed any staff to residen		
					abuse or mistreatment since		
		ange Minimum Data Set (MDS)			2/07/23. Documentation is		
	assessment, dated 1	/4/23, indicated the resident			available for review.		
	was cognitively imp	paired for daily decision					
	making.				Measures to Ensure the		
					Deficient Practice Does Not		
	Interview with the DON on 2/7/23 at 4:00 p.m., indicated she was aware of the situation and the				Recur		
					All staff have been re-educate		
	allegation was not substantiated based on her				the need to immediately repor		
	investigation. Administrative Assistant 1 and				the Administrator and the DOI		
	-	icated Employee 1 had been			any allegations of abuse inclu	ding	
		ay and he told the resident to			staff to resident or resident to	_	
		the hall because the floor was			resident abuse. They are awa		
		rant her to get hurt. The			their responsibility to cooperate		
		ry of walking from the dining			during any investigation follow	<i>i</i> ing	
	room to her room a	nd back on a frequent basis.			an allegation of abuse or		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED	
		155845	B. W	ING		02/07/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIE	R			21ST AVE		
SIMMON	S LOVING CARE I	HEALTH FACILITY			IN 46407		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d the employee had not been			mistreatment.		
		investigation because the					
	_	ounded. Activity Aide 1			The Administrator and the DO	_	
	_	byee had been called into the			are aware of their responsibil	-	
	1	ng day to be interviewed. The			report immediately but not lat		
		en the resident and employee			than 2 hours after being alert		
		ogether, the resident stated the			any allegation involving abus	e,	
		to her and she had no issues.			neglect, exploitation or	,	
		e Assistant indicated the			mistreatment, including injuri	es of	
		in October or November of			unknown source and		
	2022.				misappropriation of resident	Ja - 3	
	Nama and Nieter 1 4	A 11/2022 through 2/7/22			property. They are aware of t	neir	
		ed 11/2022 through 2/7/23,			responsibility to ensure all		
		s no documentation related to			allegations are thoroughly	:41_	
	the allegation of ab	ouse.			investigated in accordance w	ำเก	
	Further interview	with the DON of 4.25 m			facility policy.		
		with the DON at 4:25 p.m., ucted an investigation but had			Upon completion of investing	tion	
		She also indicated the			Upon completion of investiga		
		rvice Director was supposed to			D.O.N. will submit report to the Administrator and nurse	ie	
	document somethin				consultant for review. Any		
	document somethin	15.			modifications or recommenda	ations	
	The last Social Sar	vice progress note was dated			will be indicated and docume		
	9/12/22.	vice progress note was dated			in the investigation summary		
	21 12 12 2 L				in the investigation summary.	•	
	The facility abuse j	policy, provided by the DON			The Administrator and the D0	NC	
	on 2/7/23 at 4:30 p	.m., indicated it was the policy			are committed to following fa	cility	
	of the facility that i	reports of "abuse"			policy and federal regulations	and	
		lect, or abuse, including injuries			will ensure that compliance w	/ith	
	of unknown source				both is achieved and maintain	ned.	
	misappropriation of property) were promptly and thoroughly investigated. The investigation was the process used to try and determine what happened. The designated facility personnel would begin the investigation immediately. A						
					The Monitoring Process to		
					Ensure the Deficient Practic	e	
					Does Not Recur		
		ation and analysis would be			The charge nurse is to monite	or for	
	_	formation gathered was to be			abuse during each shift and r	ecord	
	given to administra	ation.			any allegations of abuse on t		
					shift to shift monitoring form f	or	
	The abuse policy a	lso indicated when an incident			abuse. The form indicates th	e	

02/28/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/07/2023 155845 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN 46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE or suspected incident of "abuse" was reported, date of the allegations of abuse, the Administrator or designee would investigate type of abuse, date and time the incident with the assistance of appropriate reported to D.O.N. The form is personnel. The investigation would include: then given to the administrator for completion that indicates the time i. Who was involved and date it was reported to ISDOH and conclusion of the investigation ii. Residents' statements whether justified or non-justified. a. For non-verbal residents, cognitively The Social Worker will meet impaired residents or residents who refuse to be individually with all interviewable interviewed, attempt to interview the resident residents and ask key questions first. If unable, observe resident, complete an related to their quality of life and evaluation of resident behavior, affect and care including staff treatment. Five response to interaction, and document findings. interviews will be conducted weekly and residents rotated so

iii. Resident's roommate statements (if applicable).

iv. Involved staff and witness statements of events.

v. A description of the resident's behavior and environment at the time of the incident.

vi. Injuries present including a resident assessment.

vii. Observation of resident and staff behaviors during the investigation.

viii. Environmental considerations.

All staff must cooperate during the investigation to assure the resident was fully protected.

This Federal tag relates to Complaint IN00396194.

3.1-28(d)

that all interviewable residents will be interviewed at least once per month on-going. The results of these interviews will be documented and provided to the Administrator at the conclusion of each week.

D.O.N. will submit her written investigation results to the Administrator and nurse consultant for review.

Administrator and nurse consultant will review investigation report within 24 hours. Any recommended modifications or additional information needed will be indicated and completion of investigation will be documented.

Facility policy will be reviewed and modified to include the additional procedures.

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

PRINTED: 02/28/2023

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N							
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPL	ETED		
		155845	B. WING		02/07/	2023	
	PROVIDER OR SUPPLIE	R HEALTH FACILITY	700 E 2	ADDRESS, CITY, STATE, ZIP COD 21ST AVE IN 46407			
(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 O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				Any resident concerns identifice through the interviews will be addressed by administrative so with a written plan; the plan with submitted to the QAPI committed for review. Further corrective actions will be developed and implemented as deemed necessary. DATE:2/21/23	taff ll be		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y2ZE11 Facility ID: 000368 If continuation sheet Page 10 of 10