PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	MEDICARE & MEDIC	•				B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		COMPL	
		155230	B. WING		05/24/	/2023
	ROVIDER OR SUPPLIEF		2	TREET ADDRESS, CITY, STATE, ZIP C 2050 CHESTER BLVD RICHMOND, IN 47374	OD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D PROVIDER'S PLAN OF CORI	DECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	Т	AG DEFICIENCY)	PPROPRIATE	DATE
E 0000						
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/24/23 Facility Number: 000135 Provider Number: 155230 AIM Number: 100266820 At this Emergency Preparedness survey, Rosebud Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 110 certified beds. At the time of the survey, the census was 95. Quality Review completed on 05/30/23		E 0000	E 0000 Dear Brenda Buroker, Attached is Rosebud Village plan of correction for Life Sa Code with Emergency Preparedness Survey compon 5/24/2023. Rosebud Villarequesting paper compliance all deficiencies written in the Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director		
K 0000						
Bldg. 01	Licensure Survey w Department of Head 483.90(a). Survey Date: 05/24 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety	00135 155230	K 0000	Dear Brenda Buroker, Attached is Rosebud V plan of correction for Li Code with Emergency Preparedness Survey on 5/24/2023. Rosebu requesting paper compall deficiencies written Please accept the plan correction as written.	fe Safety completed d Village is liance for in the 2567.	
	I Sund not in Co	1		maint you,		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE		(X6) DATE

Kari Alcorn 06/16/2023

Any defiency statement 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

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 disclodays 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: 3MVX21 Facility ID: 000135 If continuation sheet Page 1 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	 UILDING	onstruction 01	(X3) DATE COMPI 05/24/	ETED
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HESTER BLVD		
ROSEBL	JD VILLAGE			OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	for Participation in Subpart 483.90(a), 2000 edition of the Association (NFPA	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and		Kari Alcorn, HFA Executive Director		
	type V (000) constr The facility has a fi- detection in the corr corridors and batter all resident sleeping	ity was determined to be of uction and was fully sprinkled. re alarm system with smoke ridors, spaces open to the y-operated smoke detectors in grooms. The facility has a had a census of 95 at the time				
	were sprinkled and services were sprink	idents have customary access all areas providing facility kled. The facility has one corage building used for not sprinkled.				
	Quality Review con	mpleted on 05/30/23				
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security new used, only one lock permitted on each be made for the research.	d means of egress shall not a latch or a lock that if a tool or key from the susing one of the following rangements: SOR SECURITY THREAT king arrangements for the peds of the patient are eking device shall be a door and provisions shall apid removal of occupants of locks; keying of all				

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

Event ID:

3MVX21 Facility ID: 000135

If continuation sheet Page 2 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	, ,	UILDING	nstruction 01	(X3) DATE COMPI 05/24	LETED
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			2050 CH	NDDRESS, CITY, STATE, ZIP COD HESTER BLVD OND, IN 47374			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION
TAG	locks or keys carrother such reliabl staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the Clinical or Seare being met. In electrical locks the release upon loss building is protected automatic sprinkles space is protected detection system at an attended loc space); and both systems are arraic upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, sup detection system automatic sprinkles 18.2.2.2.4, 19.2.2 ACCESS-CONTELOCKING ARRA Access-Controlles installed in according the permitted. 18.2.2.2.4, 19.2.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.4 19.2.2 19.2.2 19.2 19.2 19.2 1	cking arrangements for the be patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to so of power to the device; the ted by a supervised er system and the locked d by a complete smoke (or is constantly monitored cation within the locked the sprinkler and detection aged to unlock the doors 2.2.2.5.2, TIA 12-4 ESS LOCKING S delayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by the ervised automatic fire or an approved, supervised er system. 2.2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall		TAG			DATE

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

Event ID:

3MVX21 Facility ID: 000135

If continuation sheet Page 3 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155230	B. WING 05/24/2023					
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			HESTER BLVD			
ROSEBL	JD VILLAGE				OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	LOCKING ARRA							
	1	it access door locking in						
		7.2.1.6.3 shall be permitted						
		es in buildings protected						
		approved, supervised						
		ection system and an						
	1 ' '	ised automatic sprinkler						
	system.							
	18.2.2.2.4, 19.2.2							
		on and interview, the facility	K 0	222	K 222 Egress Doors		06/15/2023	
		of over 10 means of egress were			What corrective action will be			
	•	or residents without a clinical			accomplished for those reside			
		specialized security measures.			found to have been affected b	y the		
	_	uired means of egress shall not			deficient practice?			
		latch or lock that requires the			The facility will post codes to			
	-	from the egress side unless			doors in an obvious fashion a			
	_	d by LSC 19.2.2.2.4.			exit door located at the emplo	yee		
	_	gements shall be permitted in 0.2.2.2.5.2. This deficient			entrance/exit.			
	practice could affect	et 4, staff and visitors if			How other residents having th	ie		
	needing to exit the	facility.			potential to be affected by the			
					same deficient practice will be	,		
	Findings include:				identified and what corrective			
					action will be taken?			
		ons and interview during a			All residents with access to ex	кit		
		with the Executive Director and			doors have the potential to be	;		
		tor on 05/24/23 between 11:45			affected by the alleged deficie	ncy.		
		the exit door, marked as a			The code is now posted at the	exit		
	-	service hall corridor was			door in an obvious fashion. (S	ee		
		d and could be opened by			attachment) The maintenance			
		it code but the code was not			director or designee will condu	uct		
	_	enance Director stated that the			rounds to ensure that codes a			
		e but had either fallen off or			posted in an obvious fashion.	Any		
	been removed.				issues will be immediately			
					rectified.			
		cknowledged by the Executive						
		enance Director at the time of			What measures will be put int			
		n at the exit conference with			place and what systemic char	ıges		
	the Executive Direct	ctor and Maintenance Director			will be made to ensure the			
	nrecent		1		deficient practice does not rec	sur2	1	

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMP: 05/24	
	PROVIDER OR SUPPLIER		2050 C	ADDRESS, CITY, STATE, ZIP CC CHESTER BLVD IOND, IN 47374	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE	(X5) COMPLETION DATE
	3.1-19(b)			Maintenance director or will do an audit of the fa ensure that codes are p an obvious fashion. Any will be immediately recti Maintenance director or with do a monthly walk ensure compliance. Exedirector to monitor for compliance. How the corrective action monitored to ensure the practice will not recur an quality assurance progruput into place? Maintenance director or with do a monthly walk exix months to ensure con with results brought to creview. If a threshold of met, an action plan will developed to ensure con Executive director to monitore. What date will systemic be completed? 6/15/23	cility to osted in vissues ified. designee through to ecutive on will be deficient am will be designee through for ompliance QAPI for 90% is not be mpliance. onitor for	
K 0271 SS=E Bldg. 01	7.7, provides a level the provisions of 7 changes in elevations of obstruction					

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

Event ID:

3MVX21

Facility ID: 000135

If continuation sheet

Page 5 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			LETED
		155230	B. WING 05/24/2023				/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			HESTER BLVD		
ROSERI	JD VILLAGE				OND, IN 47374		
	, o vice, (OE			1 (101 1101	, 11 71017		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	ĺ	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	18.2.7, 19.2.7						
		on and interview, the facility	K 0	271	K 271 Discharge from Exits		07/31/2023
		f over 4 exit discharges had a					
	_	ce, were free of obstructions,			What corrective action will be		
		hard packed all-weather travel			accomplished for those reside		
		ce with CMS Survey and			found to have been affected b	y the	
		05-38. This deficient practice			deficient practice?		
	could affect 12 residuely	dents and staff.			The facility will replace/repair	exit	
					discharge sidewalk that is		
	Findings include:				uneven/unlevel in the courtya	•	
					7/31/23. The facility has secu		
		ons and interview during a			an outside vendor to complete		
		with the Executive Director and			sidewalk repairs/replacement.		
		tor on 05/24/23 between 11:45			The facility has identified the		
	_	the exit discharge sidewalk in			unlevel surface by brightly col		
		large crack in the concrete,			paint until the replacement/rep	oair	
		rise in separation created a			is completed.		
	trip hazard. The Ma				The facility has secured an		
	_	the walkway was in need of			outside vendor to remove the		
	_	nplete level walking surface			from the area that is causing t	he	
	-	hazards leading to the			sidewalk to become uneven.		
		g that the tree roots cause the			How other residents having th		
		I that this has been a problem			potential to be affected by the		
	in the past.				same deficient practice will be)	
					identified and what corrective		
		knowledged by the Executive			action will be taken?		
		enance Director at the time of			All residents who have access		
		at the exit conference with			the exit discharge sidewalk in		
		ctor and Maintenance Director			courtyard have the ability to be		
	present.				affected by the alleged deficie		
					practice. The maintenance dir		
	3.1-19(b)				has inspected all exit discharg		
					sidewalks to ensure that surfa	ces	
					are level and free from		
					obstructions.		
					What measures will be put into		
					place and what systemic char	nges	
					will be made to ensure the	_	
					deficient practice does not rec	cur?	

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155230	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 4/2023
	ROVIDER OR SUPPLIER		2050 C	ADDRESS, CITY, STATE, ZIP C CHESTER BLVD MOND, IN 47374	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				Maintenance director of will do an audit of the f discharge sidewalks to that surfaces are level from obstructions. Any be immediately rectifie Maintenance director of with do a monthly walk ensure compliance. Ex director to monitor for compliance. How the corrective act monitored to ensure the practice will not recur a quality assurance progrut into place? Maintenance director of with do a monthly walk six months to ensure of with results brought to review. If a threshold of met, an action plan will developed to ensure of Executive director to monthly compliance. What date will systemic be completed? 7/31/23	acility exit ensure and free issues will d. or designee through to eccutive ion will be e deficient and what gram will be or designee through for ompliance QAPI for of 90% is not I be ompliance. nonitor for	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment les that have been				

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

Event ID:

3MVX21

Facility ID: 000135

If continuation sheet

Page 7 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED OF 124 (2022)	
		155230	B. WING		05/24/2023	
	PROVIDER OR SUPPLIE	R	2050	ET ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD IMOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION	
	assembled by que the conditions of the patient care won non-PCREE (e.g. except in long-tend do not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care other UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 90.3 Based on observation failed to ensure 1 of powering medical powering non-medical powering include: Based on observation of the facility Maintenance Direct a.m. and 1:45 p.m. plugged in to a power non-medical person. This finding was a Director and Main discovery and again to a goal of the facility of the facility was a director and Main discovery and again discovery and again to a power non-medical person.	alified personnel and meet 10.2.3.6. Power strips in ricinity may not be used for personal electronics), and care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms by meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension as a substitute for fixed are. Extension cords used emoved immediately upon purpose for which it was ests the conditions of 10.2.4. (P), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 (D)	K 0920	K 920 Electrical Equipment What corrective action will be accomplished for those resifound to have been affected deficient practice? The facility separated medice equipment and non-medical equipment into separate appower strips(UL1363 & UL1363A)/outlets. The facility purchased addite approved power strips(UL13UL1363A) so that medical anon-medical equipment can separated. How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken?	oe dents I by the cal I proved ional 363 & and be the ne be	

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

Event ID:

 $3MVX21 \qquad {\tt Facility \, ID:} \quad 000135$

If continuation sheet

Page 8 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155230		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/24/2023	
	PROVIDER OR SUPPLIE	ER	2050 C	ADDRESS, CITY, STATE, ZIP COD CHESTER BLVD MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE
REGULATORY OR LSC IDE 3.1-19(b)			All residents who utilize me and non-medical equipmen power strips have the poter be effected by this alleged deficient practice. The maintenance director or deswill conduct rounds to ensu medical equipment and non-medical equipment are plugged into the same power Any issues will be immediat rectified.	dical t and ntial to signee re that not er strip. tely	
				What measures will be put place and what systemic che will be made to ensure the deficient practice does not a The maintenance director of designee will conduct round ensure that medical equipment and non-medical equipment not plugged into the same patrip. Any issues will be immediately rectified. Maintenance director or deswith do a monthly walk throensure compliance. Execut director to monitor for comp	recur? Is to the second of th
				How the corrective action we monitored to ensure the determination of the practice will not recur and we quality assurance program put into place? Maintenance director or deswith do a monthly walk through six months to ensure complewith results brought to QAP review. If a threshold of 90%	ficient /hat will be signee ugh for liance

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

Event ID:

3MVX21

Facility ID: 000135

If continuation sheet

Page 9 of 10

PRINTED: 06/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155230	B. WING		05/24/2023		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				met, an action plan will be			
				developed to ensure compliar	nce.		
				Executive director to monitor	for		
				compliance.			
				What date will systemic chang be completed? 6/30/23	ges		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3MVX21 Facility ID: 000135 If continuation sheet Page 10 of 10