DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
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		345175	B. WING				C 14/2014
NAME OF F	NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
OMITUEI	SMITHFIELD MANOR INC			F	POST OFFICE BOX 1940		
31411 111	ELD MANOR INC			S	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 SS=D	been found guilty or mistreating residen had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and co The facility must haviolations are thoro prevent further pote investigation is in p The results of all in to the administrator	PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or o the State nurse aide registry ties. usure that all alleged violations tent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 2	225			8/28/14
	with State law (inclu certification agency incident, and if the appropriate correct	uding to the State survey and ) within 5 working days of the alleged violation is verified ive action must be taken.					
LABORATOR	INTECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

## **Electronically Signed**

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.

08/28/2014

PRINTED: 08/29/2014

	-	AND HUMAN SERVICES			FO	RM A	08/29/2014 PPROVEI )938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		345175	B. WING	B. WING			4/2014
NAME OF F	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIELD MANOR INC					POST OFFICE BOX 1940 SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 225	Continued From pa This REQUIREMEI by:	age 1 NT is not met as evidenced	F 2	25			
	Based on observa- records review, the 24 hours and inves origin to the state a residents reviewed Resident #1 was ac cumulative diagnos quarterly Minimum indicated Resident impairment and rec with all activities of A review of a nursir incident report date AM, a bruise was n eye. The physician (RP) were notified.	ng note dated 8/10/14 and an ed 8/10/14 indicated at 10:00 loted to Resident #1 ' s left and the responsible party			For Resident #1, a 24-Hour Initial Repr and a 5-Working Day Report were completed within 24 hours of complaint survey exit. The 24-Hour Initial and 5-Working Day reports were completed per guidance of Judith Jackson, Johnst County investigator for the North Caroli Department of Health & Human Service Health Care Personnel Registry. Facility policy entitled "Resident Abuse and Prohibition Policy and Procedures, revised to reflect reporting of allegation of abuse, neglect and/or misappropriati of property to the Health Care Personn Registry Of Division Of Facility Services within 24 hours and removing clause "c as soon as practicable."	t ton ina es is ion el s	
	Clinical Services (D request of the RP of bruise. The grievan completed with stat the DON and a follo RP. The grievance determined but a n implemented by pa grievance also indio bed mobility was do done by the DOCS observed at 5:30 A identified on 8/10/1 nursing assistant (N	was started by the Director of DOCS) on 8/11/14 at the questioning the cause of the ace was dated and signed as ff interviewed on 8/13/14 by ow up call was made to the indicated the cause was not ew intervention was dding the one side rail. The cated that staff education with one. A review of the interviews indicated the bruise was not M Sunday morning and first 4 at 9:30 AM by the assigned NA).			Facility policy entitled "Resident Abuse and Prohibition Policy and Procedures, revised to reflect the definition of "injuri of unknown source" to include condition in which they are classified by, per the interpretive guidelines of state regulation 483.13. Disciplinary warning notice completed 8/25/14 for Director of Clinical Services (DOCS) regarding non-compliance of policy entitled "Resident Abuse Prohibit Policy and Procedures," and her failure notify the administrator. Acknowledgement of understanding an future compliance obtained.	es ns on tion to	
		oserved lying on the left side			The Staff Development Coordinator sha	all	

Facility ID: 923459

		AND HUMAN SERVICES			0		APPROVE 0938-039	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245475	B. WING			С		
		345175	B. WING			08/1	14/2014	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SMITHFI	ELD MANOR INC				OST OFFICE BOX 1940 MITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE	
F 225	with a nebulizer ma face. NA #1 remove bruise under the lef elastic strap where Yellowish discolorat There were numero discolorations to Re disorder called Bull in blisters on the sk was on the right sid padded. NA #1 stat to turn or reposition A review of Resider 6/9/14 indicated sho the mediation admi revealed Resident a daily for the inflamm Pemphigoid. A com Prednisone use res In an interview on 8 DOCS recalled the Monday 8/11/14 indicated on 8/10.	isk covering the nose and ed to mask to reveal a linier if eye that was covered by the the nebulizer was placed. tion surrounded the left eye. bus areas of scabbing and esident #1's skin due to a ous Pemphigoid which results tin. The only observed side rail le of the bed and it was ed Resident #1 was not able in bed independently. In #1's most recent labs dated e was anemic and a review of nistration record for August #1 was prescribed Prednisone nation associated with Bullous imon side effect of prolonged sults in bruising easily. B/14/14 at 12:02 PM, the RP approaching her on quiring about the bruise /14. The DOCS stated she	F 2	225	conduct facility wide in-services of departments to include, but not lim the revised policy entitled "Resider Abuse Prohibition Policy and Proce The Staff Development Coordinato provide education related to all components of the policy to include screening, training, prevention, investigation and reporting/respons include emphasis of the timely repo- allegations within 24 hours and the definition and understanding of "inj unknown source." In-services to a departments will be utilized to esta facility expectations. Continued ye in-services and all new hires will re this training conducted by the Staff Development Coordinator. Bi-weekly audits entitled "Abuse Notification Audit" are to be complet the Quality Assurance coordinator his/her designee X 1 quarter, and quarterly thereafter. These audits include all departments and encom	hited to, at edures." or will e se and orting of uries of ll blish arly ceive eted by or shall pass		
	was started becaus and she knew it wo since the origin was she began calling th Resident #1 on Sat DOCS stated she d who completed the that it may have occ staff member rolled eye on the unpadde rail padded on 8/11 facility on Wednesd	e bruise but a grievance form se the DON was off Monday uld need to be investigated s unknown. The DOCS stated he staff who worked with urday and Sunday. The lid not speak to the nurse #1 incident report but she felt curred during care when a I her over and she bumped her ed side rail. She had the side /4.The RP returned to the lay 8/13/14 and again inquired of the investigation. She			questioning to ensure facility emplo are knowledgeable and compliant i regards to the policy entitled "Resid Abuse Prohibition Policy and Proce in relation to timely reporting of alle within 24 hours. These audits shall included in the agenda of the quart Quality Assurance Committee mee and be monitored for correction, achievement and sustainment of th revised policy. Date of completion of corrective ac August 29, 2014.	in dent edures," egations be be rerly eting ne		

Facility ID: 923459

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/29/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COMI	E SURVEY PLETED
		345175	B. WING	i			C 14/2014
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIELD MANOR INC					POST OFFICE BOX 1940 SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	stated she had not nurse #1 who comp she had spoken to Resident #1 and no bruise had been ide RP requested the D investigation. The D inform the SDC or t grievance she was until Wednesday 8/ In a telephone inter nurse #1 stated on a bruise to Residen the bruise and notif She stated Resider left side and resting completed an incide for the DOCS to do nobody from the fac regarding the incide In an interview on 1 #1 was an administ expectation was shi the investigation. T grievance and the in DOCS with the staf form on intential inju #1. In an interview on 8 stated she became 8/13/14 when the D education on bed m stated when an inju identified the facility grievance then doe	had an opportunity to contact bleted the incident report but the other staff working with cause for the source of the entified. It was at this time, the DON take over the DOCS stated she did not the DON of the bruise or the working on behalf of the RP 13/14. view on 8/13/14 at 1:05 PM, Sunday the NA notified her of t #1's left eye. She assessed ied the physician and the RP. It #1 had a habit of lying on the pher face on her fist. Nurse #1 ent report and left the report an investigation. She stated cility had contacted her to date	F2	225	5		

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		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 08/29/20 FORM APPROVE OMB NO. 0938-03					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345175	B. WING				C 14/2014		
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
SMITHFIELD MANOR INC			POST OFFICE BOX 1940 SMITHFIELD, NC 27577						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 225	knowledge. In and interview on administrator and the stated the RP asket 8/13/14. The DON v incident at this time became involved are the possibility she w bumped the side ra expectation was that unknown origin was reported using the 2	incident without her 8/14/14 at 2:00 PM with the be DON, the administrator d him about the bruise on was also unaware of the . It was at that point the DON nd spoke with the RP about vas turned and her face il. The administrator stated his at when an incident or injury of a identified, it would be 24 hour report and 5 day gency and the investigation	F 2	225					
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle and misappropriatio	P/IMPLMENT ETC POLICIES velop and implement written ures that prohibit ect, and abuse of residents on of resident property.	F 2	226			8/28/14		
	by: Based on staff inte facility failed to deve to identify and inves origin for 1 of 3 resi Findings included: The facility provided Abuse Prohibition F date revised of 200	<ul> <li>NT is not met as evidenced</li> <li>rviews and records review the elop a policy and procedures</li> <li>stigation an injury of unknown dents reviewed for injury.</li> <li>d their policy titled "Resident Policy and Procedures" with</li> <li>9. A review of the facility ntion of the identification of</li> </ul>			Facility policy entitled "Resident Ab and Prohibition Policy and Procedur revised to reflect reporting of allega of abuse, neglect and/or misapprop of property to the Health Care Perso Registry Of Division Of Facility Serv within 24 hours and removing claus as soon as practicable." Facility policy entitled "Resident Abu	res," tions priation onnel vices se "or			

Facility ID: 923459

If continuation sheet Page 5 of 8

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
					(	С	
		345175	B. WING	·····		4/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
SMITHFI	ELD MANOR INC			POST OFFICE BOX 1940 SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE	
F 226	Continued From pa	ge 5	F 22	26			
	events suspicious in nature or injuries of unknown origin. The policy also read that the facility should ensure that the state agency would be notified within 24 hours or as soon as practicable of the allegation which appear to a reasonable person to be related to abuse, neglect or misappropriation of resident property.			and Prohibition Policy a revised to reflect the de of unknown source" to in which they are classi interpretive guidelines o 483.13. The Staff Development	efinition of "injuries include conditions ified by, per the of state regulation		
	Director of Nursing	AM, administrator and the (DON) identified the Staff dinator (SDC) and the DON as ators for the facility.		conduct facility wide in- departments to include the revised policy entitle Abuse Prohibition Polic The Staff Development	services of all e, but not limited to, ed "Resident y and Procedures."		
	cumulative diagnos quarterly Minimum indicated Resident	dmitted 11/13/07 with les of Parkinson Disease. The Data Set dated 7/8/14 #1 had severe cognitive guired extensive assistance daily living (ADLs).		provide education relat components of the poli screening, training, pre investigation, reporting emphasis of the timely allegations within 24 ho definition and understa	ed to all cy to include vention, /response and reporting of ours and the		
	incident report date AM, a bruise was n	ng note dated 8/10/14 and an d 8/10/14 indicated at 10:00 oted to Resident #1's left eye. the responsible party (RP)		unknown source. In-se departments will be util facility expectations. C in-services and all new this training conducted Development Coordina	ervices to all ized to establish ontinued yearly hires will receive by the Staff		
	Clinical Services (D request of the RP o bruise. The grievan completed with staf the DON and a follo RP. The grievance determined but a no implemented by pa grievance also indio bed mobility was do	was started by the Director of DOCS) on 8/11/14 at the Juestioning the cause of the ice was dated and signed as if interviewed on 8/13/14 by ow up call was made to the indicated the cause was not ew intervention was dding the one side rail. The cated that staff education with one. A review of the interviews indicated the bruise was not		Bi-weekly audits entitle Notification Audit" are to the Quality Assurance of his/her designee X 1 qu quarterly thereafter. Th include all departments questioning to ensure f are knowledgeable and regards to the policy en Abuse Prohibition Policy in relation to timely repo	d "Abuse o be completed by coordinator or uarter, and nese audits shall and encompass acility employees compliant in ntitled "Resident by and Procedures,"		

Facility ID: 923459

If continuation sheet Page 6 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE COMP	0938-0391 E SURVEY PLETED C 14/2014
345175     B. WING	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SMITHFIELD MANOR INC       POST OFFICE BOX 1940         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6 identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA).       F 226 included in the agenda of the quarterly Quality Assurance Committee meeting and be monitored for correction, achievement and sustainment of the revised policy.         DOCS recalled the RP approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown.       Date of completion of corrective action is August 29, 2014.         In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident.       Date of a true approaching her on a bruise to Resident #1's left approachin	(X5) COMPLETION
SMITHFIELD MANOR INC     SMITHFIELD, NC 27577       (x4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 226     Continued From page 6 identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA).     F 226 identified on 8/10/14 at 12:02 PM, the DOCS recalled the R approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown.     F 226 Included in the agenda of the quarterly Quality Assurance Committee meeting and be monitored for corrective, action is August 29, 2014.       In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident.	COMPLETION
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6 identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA).       F 226         In an interview on 8/14/14 at 12:02 PM, the DOCS recalled the RP approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown.       Date of completion of corrective action is August 29, 2014.         In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident.	COMPLETION
<ul> <li>identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA).</li> <li>In an interview on 8/14/14 at 12:02 PM, the DOCS recalled the RP approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown.</li> <li>In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident.</li> </ul>	
interruption of the federal guideline was the facility could include incidents of unknown origin but it was not mandated if no malicious intent was identified.	
In an interview on 8/14/14 at 2:32 PM, the SDC stated she became aware of the incident on 8/13/14 when the DON asked her to start staff education on bed mobility with Resident #1. She stated when an injury of unknown origin was identified the facility typically completes a grievance then does an investigation. She stated that if abuse was suspected, they facility had 24 hours or as soon as practicable to report the incident. In and interview on 8/14/14 at 2:00 PM with the	

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		AND HUMAN SERVICES				FORM	08/29/2014 APPROVED 0938-0391
					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	345175		B. WING				_ 14/2014
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFI	ELD MANOR INC				POST OFFICE BOX 1940 SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	administrator and the stated he was not a not include the reporting incidents of suspici unknown origin and indicated reporting administrator stated when an suspect in origin was identified the 24 hour report a	nge 7 he DON, the administrator aware that the facility policy did orting and investigation of ous in nature or incidents of d unaware that the policy as soon as practicable. The d his expectation was that incident or injury of unknown d, it was to be reported using and 5 day report to the state estigation be started	F 2	226			

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