DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			C	MB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	JILDING		COMPLETED	
						С	
		345514	B. WING			09/17/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				1210 EASTERN AVENUE			
AUTUMN	CARE OF NASH			NASHVILLE, NC 27856			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR			(EACH CORRECTIVE ACT	TION SHOULD BE	COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		EFERENCED TO THE APPROPRIATE DEFICIENCY)		
– 000							
F 000	INITIAL COMMENTS		F 0	00			
		ation survey was conducted					
	from 9/14/21 through	9/17/21. Event ID# FJ1011.					
	One of the 20 compla						
F 500	substantiated resultin					0/04/04	
F 580		jury/Decline/Room, etc.)	F 5	80		9/24/21	
SS=D	CFR(s): 483.10(g)(14	-)(I)-(IV)(IS)					
	§483.10(g)(14) Notific	cation of Changes					
		ediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe						
		ving the resident which					
	results in injury and h	as the potential for requiring					
	physician interventior						
		ge in the resident's physical,					
	mental, or psychosoc						
		n, mental, or psychosocial					
		reatening conditions or					
	clinical complications); eatment significantly (that is,					
	a need to discontinue	3					
		erse consequences, or to					
	commence a new for	-					
	(D) A decision to tran						
	resident from the faci	-					
	§483.15(c)(1)(ii).						
		fication under paragraph (g)					
		the facility must ensure that					
		on specified in §483.15(c)(2)					
		ded upon request to the					
	physician.	loo promptly potify the					
		also promptly notify the					
	when there is-	lent representative, if any,					
		or roommate assignment					
LABORATORY	, DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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.

10/06/2021

SINTEMENT OF DERIGENCIES AND PLAY OF CORRECTION [N1] PROVIDERUSIPPLIER JENTIFICATION NUMBER (22) NULTIFIC CONSTRUCTION A BUILDING (23) DATE SURVEY COMPLETED C (23) DATE SURVEY C (23) DATE SURVEY C (23) DATE SURVEY C (23) DATE SURVEY C (23) DATE SURVEY C <t< th=""><th></th><th></th><th>ID HUMAN SERVICES MEDICAID SERVICES</th><th></th><th></th><th>FORM APPRC OMB NO. 0938-0</th><th>OVED</th></t<>			ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRC OMB NO. 0938-0	OVED
346914 09/17/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STITE, 2P CODE 1210 EASTERN VERNUE NAME OF NASH (%4) ID PRETIX RECOMMENT OF DEFICIENCIES STREET ADDRESS. CITY. STITE, 2P CODE 1210 EASTERN VERNUE NAME OF NASH (%4) ID PRETIX IEACH ENCRICE VALUE THE PRECIDEND AT FULL RECOUNTORY OR LSD DENTIFITING INFORMATION) ID ID PROVIDERS PLAY OF COMRECTIVE ACTION SHOLD BE (RACH ENCRICE VALUE ACTIO	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·	E CONSTRUCTION	COMPLETED	
1210 EASTERN AVENUE NSNVILLE, NC 27865 CMUID PREVEX TRG SUMMARY STATEMENT OF DEFICIENCES (EXCH DEFICIENCY MIST BE PRECIEDED XY FULL) REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVEX TRG PROVIDER STATEMENT OF DEFICIENCES (EXCH DEFICIENCY ACTION POR LSC IDENTIFYING INFORMATION) ID PREVEX TRG PROVIDER STATEMENT OF DEFICIENCES (EXCH DEFICIENCY) OD DEFICIENCY) OD DEFICIENCY F 580 Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). F 580 F 580 F 483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in sphysical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under \$433.15(9)(0). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify resident's Responsible Party of pressure ulcer (changes for 2 of 2 resident's reviewed for pressure ulcers, (Resident #3 and 4). #1 Corrective action for affected resident Resident #3 is no longer at the facility. The responsible party for resident #4 was notified and updated on the current status of her pressure ulcer on 9/20/2021 by the ADON.	345514			B. WING		-	
AUTUMN CARE OF NASH NASHVILLE, NC 27856 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (M) (EACH OFFICENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (M) (EACH OFFICENCY CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (M) (D) DATE F 580 Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. F 580 F 580 (i) (T) The facility must record and periodically update the address (mailing and email) and phone number of the resident representiative(s). F 580 F 580 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part. A facility that is a precify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify resident \$R seponsible Party of pressure ulcer changes for 2 of 2 resident reviewed for pressure ulcers. (Resident #3 and 4). #1 Corrective action for affected resident Resident # 3 is no longer at the facility. The responsible party for resident \$4 was notified and update on the current status of her pressure ulcer on 9/20/2021 by the ADON. <td>NAME OF PI</td> <td>ROVIDER OR SUPPLIER</td> <td></td> <td>1</td> <td>STREET ADDRESS, CITY, STATE, ZIP CODE</td> <td>•</td> <td></td>	NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
Preferix Tvs (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Txs (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) comment DEFICIENCY F 580 Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (w) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). F 580 §483.10(g)(15) \$483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical comfiguration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify resident's Responsible Party of pressure ulcer changes for 2 of 2 residents reviewed for pressure ulcers. (Resident #3 and 4). #1 Corrective action for affected resident Resident # 3 is no longer at the facility. The responsible party for resident #4 was notified and updated on the current status of her pressure ulcer on 9/20/2021 by the ADON.	AUTUMN	CARE OF NASH					
 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.16(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify resident's Responsible Party of pressure ulcer changes for 2 of 2 residents reviewed for pressure ulcers. (Resident #3 and 4). Findings included: 1. Resident #3 was admitted to the facility on 05/28/21 with diagnoses that included stroke, hypertension, frailty, and general deconditioning. 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE YING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			
Resident #3 was discharge to hospital on 07/23/21.#2 How will the facility identify other like residentsRecord review of Change in Condition (CIC) Evaluation dated 06/30/21 revealed that Resident #3 was identified to have a pressure ulcer to sacrum. The pressure ulcer was measured approximately 2 centimeters (cm) in diameter0n 9/24/21, the Director of Nursing/designee completed a 30 day look back of any residents with a change in condition related to pressure ulcers to ensure that both the MD and the	F 580	as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di- §483.5) must disclose its physical configurat locations that comprise part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revif facility failed to notify of pressure ulcer chan reviewed for pressure 4). Findings included: 1. Resident #3 was are 05/28/21 with diagnos hypertension, frailty, a Resident #3 was disc 07/23/21. Record review of Chan Evaluation dated 06/3 #3 was identified to has sacrum. The pressure	 I0(e)(6); or ent rights under Federal or ns as specified in paragraph . ecord and periodically mailing and email) and resident bosite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced ew and staff interviews, the resident's Responsible Party nges for 2 of 2 residents e ulcers. (Resident #3 and dmitted to the facility on ses that included stroke, and general deconditioning. harge to hospital on ange in Condition (CIC) 80/21 revealed that Resident ave a pressure ulcer to re ulcer was measured 	F 580	 #1 Corrective action for affected reside Resident # 3 is no longer at the facility. The responsible party for resident # 4 v notified and updated on the current state of her pressure ulcer on 9/20/2021 by the ADON. #2 How will the facility identify other like residents On 9/24/21, the Director of Nursing/designee completed a 30 day look back of any residents with a changin condition related to pressure ulcers to the complete of t	vas tus he e	

Facility ID: 970979

If continuation sheet Page 2 of 7

		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 10/19/20 FORM APPROV 1B NO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345514	B. WING				C 09/17/2021	
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	CARE OF NASH				210 EASTERN AVENUE			
				N	ASHVILLE, NC 27856			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 580	Continued From page	<u>-</u> 2	F	580				
	with a necrotic (black Resident #3's Respon) middle. The nurse notified nsible Party (RP) of new nent, and consult for wound		500	responsible parties were notified of change.	any		
	physician. Record review of the	admission Minimum Data			A 30 day look back was also perforr on any resident with changes in cor to ensure the MD/responsible partie	ndition		
	#3 was cognitively im	02/21 revealed that Resident ipaired, had an indwelling d extensive assist for ersonal hygiene, and			were notified.			
	toileting. Resident #3 unstageable pressure				#3 What will you do to prevent this f recurring	from		
	dated 07/02/21 revea increased in size and	ekly wound assessment led the pressure ulcer had l measured 3.0 x 3.0 cm in bed. The family notification bleted.			To prevent this from recurring, licen nursing staff have been reeducated expectation that the MD and respon party will be notified for any change condition according to the policy.	on the sible	3	
	dated 07/05/21 revea	ekly wound assessment iled the pressure ulcer had measured 3.7 x 4.3 x 0.1 cm			This education was completed by the Director of Nursing on 9/21/2021.	ne		
	with yellow wound be	ed. The treatment order was nd physician. The family			Any licensed staff that cannot be rea within the initial reeducation time fra 24 hours, will not take an assignment they have received this reeducation	ame of nt until		
	dated 07/12/21 revea increased in size and cm and was describe necrotic (dead cells/ti	ekly wound assessment aled the pressure ulcer had I measured 11.0 x 15.0 x 0.1 ad as deteriorating with issue) wound bed. The ction was not completed.			Agency licensed nurses and newly licensed nurses will have this educa during their orientation.	hired		
	dated 07/19/21 revea	ekly wound assessment iled pressure ulcer had I measured 11.5 x 16.0 x 0.1			#4 How will you monitor and mainta ongoing compliance	iin		
	cm in size and was d with necrotic wound b	escribed as deteriorating bed. The treatment order wound physician. The family			To monitor and maintain ongoing compliance, the Director of Nursing designee will monitor any resident of			

Facility ID: 970979

If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514		(X2) MULTIPI A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 09/17/2021		
		B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1210 EASTERN AVENUE NASHVILLE, NC 27856	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIC
F 580	notification section wa Record review of Wo Management Summa wound physician perf debridement (remova Resident #3's pressu 07/12/21, and 07/19/2 During a telephone in am the wound physic responsible to notify I pressure ulcer progree During a telephone in pm Resident #3's RP not notify her of the in description of the pre that she did not recei until Resident #3 was During an interview o Nurse #3 revealed the ulcer change was doo wound assessment, (note. Nurse #3 was of #3's RP was not notific changes. During an interview o Nurse #2 revealed the responsible to notify the pressure ulcer and do nurse progress note. wound physicians do ulcer changes. Nurse the RP was notified here not document the infor	as not completed. und Evaluation and ary report revealed that the formed a bedside al of damaged tissue) for re ulcer on 07/05/21, 21. terview on 09/16/21 at 9:37 ian revealed the facility was Resident #3's RP of the ess. terview on 9/14/21 at 2:20 revealed that the facility did herease in size and ssure ulcer. The RP stated we an update of the wound at the hospital. n 09/15/21 at 10:05 am at notification for pressure cumented on the weekly CIC, or a nursing progress unable to state why Resident ied of pressure ulcer n 09/15/21 at 11:00 am at the floor nurse was	F 58	 of condition in general and changes related to pressure ulcers to ensure both the resident's MD and respons party were notified. This will be documented 5 x a week days during the morning clinical me and then weekly for 10 weeks with a completion date of 12/17/21. Date of compliance: 9/24/2021 #5 QAPI The Director of Nursing will report th results of the monitoring to the QAP committee for review and recommendations for the time frame the monitoring period or as it is ame by the committee. Will reviewed monthly for 100% compliance for 3 months. 	that ible for 14 eting a ne 1 2 e of

If continuation sheet Page 4 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345514			. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/17/2021		
			B. WING					
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
AUTUMN	CARE OF NASH				1210 EASTERN AVENUE NASHVILLE, NC 27856			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	was not notified of pre- During an interview of Assistant Director of N the floor nurse was re- change in wound size and update if stable of wound rounds. The A documented notificati progress note or the w 2. Resident #4 was an 03/15/19 with diagnose end stage renal disea renal dialysis, epileps sacrum, and stroke. The most recent Minin 07/10/21 indicated Re- intact. She required e ADLs, turning, reposit Resident #4 was code pressure ulcers prese Record review of the dated 04/16/21 revea increased in size from measured 8.5 x 10.2 tunneling (passagewa and 5% bone exposed section was not comp Record review of the dated 04/23/21 revea size from previous as 8.5 x 10.1 x 1.8 cm w 5% bone exposed. T	essure ulcer changes. In 09/15/21 at 12:40 pm the Nursing (ADON) revealed esponsible to notify the RP of e or description, new orders, or declined after weekly ADON stated the floor nurse on of the RP in a nurse weekly wound assessment. dmitted to the facility on ses that included diabetes, use with dependence on y, stage 2 pressure ulcer to mum Data Set (MDS) dated esident #4 was cognitively extensive assistance for tioning, and transfers. ed for stage 3 and stage 4 ent on admission/reentry. weekly wound assessment led the pressure ulcer n previous assessment and x 1.7 centimeters (cm) with ay under the skin) of 2.0 cm d. The family notification	F	580				

If continuation sheet Page 5 of 7

						FORM): 10/19/2021 MAPPROVED
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		345514	B. WING		_		C 17/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	210 EASTERN AVENUE			
AUTUMN	CARE OF NASH		N	ASHVILLE, NC 27856			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	5	F 580				
	dated 06/08/21 revea size from previous as 8.0 x 12.0 x 1.4 cm w 10% bone exposed. as unable to progress family notification sec During an interview of Nurse #3 revealed tha pressure ulcers was of wound assessment, O note. Nurse #3 was u #4's RP was not notific changes. During a telephone in am the wound physic responsible to notify F pressure ulcer progre During a telephone in pm Resident #4's RP pressure ulcer update received any updated months. During an interview of Nurse #2 revealed the responsible to notify F pressure ulcer progre notification in a nursin Nurse #2 reviewed re provide nursing notes pressure ulcer update	locumented on weekly CIC, or in a nursing progress inable to state why Resident ed of pressure ulcer terview on 09/16/21 at 9:37 an revealed the facility was Resident #4's RP of the ss. terview on 09/14/21 at 1:38 revealed she had received as weekly, but she had not information for several n 09/15/21 at 11:00 am e floor nurse was Resident #4's RP weekly on ss and document the ig progress note or CIC. cord and was unable to or CIC for notification of is to RP. Nurse #2 was esident #4's RP was not					

Facility ID: 970979

If continuation sheet Page 6 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 10/19/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345514			B. WING		_	C 09/17/2021
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
AUTUMN	CARE OF NASH			1210 EASTERN AVENUE NASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 580	During an interview o Nurse #1 revealed the condition has not been the facility and that the the resident RPs on p During an interview o Assistant Director of I the floor nurse was re- updated pressure ulc that included improve treatment change. During an interview o Administrator revealed in condition was com	n 09/15/21 at 11:11 am at notification of change in an identified as problem at e floor nurse had updated pressure ulcer progress. n 09/15/21 at 12:40 pm the Nursing (ADON) revealed esponsible to provide weekly er information to resident RP ement, decline, stability, and n 09/15/21 at 12:59 pm the d that notification of change	F 58	0		

Facility ID: 970979

If continuation sheet Page 7 of 7