			(X3) DATE SURVEY COMPLETED		
					R
		MHL026-822	B. WING		01/26/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
FRESH ST	TART RESIDENTIAL FAC	ILITY. INC	RIAN DRIVE EVILLE, NC 2831	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	January 26, 2023. De	up survey was completed eficiencies were cited.			
	category: 10A NCAC	27G .5600C Supervised Developmental Disabilities.			
		d for 6 and currently has a very sample consisted of ents.			
V 120	27G .0209 (E) Medica	ation Requirements	V 120		
	and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degre refrigerator is used fo shall be kept in a sep or container; (C) separately for each (D) separately for ext (E) in a secure manne for a client to self-med (2) Each facility that in controlled substances registered under the I	e: Ill be stored: ed cabinet in a clean, d room between 59 degrees enheit; required, between 36 ees Fahrenheit. If the r food items, medications arate, locked compartment th client; ernal and internal use; er if approved by a physician dicate. naintains stocks of s shall be currently North Carolina Controlled 90, Article 5, including any			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		MHL026-822	B. WING		01	R / 26/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
FRESH ST	TART RESIDENTIAL FAC	ILITY. INC	DRIAN DRIVE			
OVA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	TEVILLE, NC 28314	PROVIDER'S PLAN OF C	OPPECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 120	Continued From page	e 1	V 120			
	failed ensure medicat	as evidenced by: ns and interviews the facility tions were securely locked nts (#2) The findings are:				
	-28 year old maleAdmission date of 11 -Diagnoses of Charge	of client #2 record revealed: 1/15/13. e Syndrome, Moderate nental Disability, and Deaf.				
	Extra Strength eye dr Fluticasone Prop 50m on the desk not locke During interview on 0 revealed:	ichen area and Pataday rops and 3 boxes of ncg nose spray were sitting rd up in a secure area.				
	all the medication was	s removed from the desk sed medication cabinet.				
V 121	27G .0209 (F) Medica	ation Requirements	V 121			
	governing body or op for obtaining a review regimen at least ever shall be to be perform physician. The on-site the client's physician the review when med	es psychotropic drugs, the erator shall be responsible of each client's drug y six months. The review ned by a pharmacist or e manager shall assure that is informed of the results of lical intervention is indicated.				

Division of Health Service Regulation

STATE FORM S5IT11 If continuation sheet 2 of 8

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
74101214			A. BUILDING: _			
		MHL026-822	B. WING		01/2	R 26/2023
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
FRESH ST	TART RESIDENTIAL FAC	CILITY, INC	ADRIAN DRIVE ETTEVILLE, NC 283 [,]	14		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 121	Continued From page	e 2	V 121			
	corrective action, if a					
	This Rule is not met Based on record revifacility failed to perform drug regimens of clie medications, affecting clients (#1, #3 and #4 Finding #1 Review on 01/25/23 revealed: -26 year old maleAdmission date of 0 Diagnoses of Attenti Disorder Combined Truly Retardation and Chrossian record revealed to the combined of the combined	as evidenced by: ews and interviews, the rm six-month reviews of the nts receiving psychotropic g three of three audited 4). The findings are: of client #1's record				
	Medication Administr	of client #1's January 2023 ation Record (MAR) g medication regimen:				
	-Cetirizine 10mg					
	-Fanapt 12mg					
	-Fluoxetine 40mg -Guanfacine ER 3mg	l				
	-Topiramate 100mg					
	-Vitamin D2 1.25mg					
	-Vraylar 3mg					
	Finding #2					
	Review on 01/25/23	of client #3's record				
	revealed:					
	-30 year old male.					

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STATE FORM S5IT11 If continuation sheet 3 of 8

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			E SURVEY PLETED
	MHL026-822	B. WING		01	R / 26/2023
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
TART RESIDENTIAL FAC	ILITY INC. 7866 AD	RIAN DRIVE			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	FAYETTI	EVILLE, NC 2831	4		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	3	V 121			
-Diagnoses of Modera Developmental Disord Schizophrenia Spectr -The last drug regime 03/30/22. Review on 01/25/23 of Medication Administrate revealed the following -Aripiprazole 15mg -Benztropine MES 1m -Vitamin D3 50, 000 u	ate Intellectual der, Unspecified um. n review completed was of client #3's January 2023 ation Record (MAR) g medication regimen:				
Review on 01/25/23 of revealed; -49 year old maleAdmission date of 12 -Diagnoses of Schizo. Type.	2/03/06. affective Disorder, Bipolar				
Medication Administrarevealed the following -Chantix 1mg -Atorvastatin 20mg -Cetirizine 10mg -Diltiazem 24h 360mg -Ferrous Sulfate 325n -Divalproex Sod Dr 50 -Haloperidol 1mg -Losartan-Hydrochlore -Metoprolol Tartrate 2 -Olanzapine 20mg -Xigduo XR 10mg	ation Record (MAR) g medication regimen: g ng ng 00mg othiazide 50-12.5mg 5mg				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page -Admission date of 03 -Diagnoses of Modera Developmental Disord Schizophrenia Spectr -The last drug regime 03/30/22. Review on 01/25/23 of Medication Administrate revealed the following -Aripiprazole 15mg -Benztropine MES 1m -Vitamin D3 50, 000 of Finding #3 Review on 01/25/23 of revealed; -49 year old male. -Admission date of 12 -Diagnoses of Schizon Type. -The last drug regime 03/30/22. Review on 01/25/23 of Medication Administrate revealed the following -Chantix 1mg -Atorvastatin 20mg -Cetirizine 10mg -Ditliazem 24h 360mg -Ferrous Sulfate 325r -Divalproex Sod Dr 50 -Haloperidol 1mg -Losartan-Hydrochlore -Metoprolol Tartrate 2 -Olanzapine 20mg -Xigduo XR 10mg	MHL026-822 ROVIDER OR SUPPLIER STREET A TART RESIDENTIAL FACILITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 -Admission date of 03/04/10Diagnoses of Moderate Intellectual Developmental Disorder, Unspecified Schizophrenia SpectrumThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #3's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Aripiprazole 15mg -Benztropine MES 1mg -Vitamin D3 50, 000 units Finding #3 Review on 01/25/23 of client #4's record revealed; -49 year old maleAdmission date of 12/03/06Diagnoses of Schizoaffective Disorder, Bipolar TypeThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Chantix 1mg -Atorvastatin 20mg -Cetirizine 10mg -Diltiazem 24h 360mg -Ferrous Sulfate 325mg -Divalproex Sod Dr 500mg -Haloperidol 1mg -Losartan-Hydrochlorothiazide 50-12.5mg -Metoprolol Tartrate 25mg -Olanzapine 20mg	ROVIDER OR SUPPLIER TART RESIDENTIAL FACILITY, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 -Admission date of 03/04/10Diagnoses of Moderate Intellectual Developmental Disorder, Unspecified Schizophrenia SpectrumThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #3's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Aripiprazole 15mg -Benztropine MES 1mg -Vitamin D3 50, 000 units Finding #3 Review on 01/25/23 of client #4's record revealed; -49 year old maleAdmission date of 12/03/06Diagnoses of Schizoaffective Disorder, Bipolar TypeThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Chantix 1mg -Atorvastatin 20mg -Cetirizine 10mg -Cetirizine 10mg -Diltiazem 24h 360mg -Ferrous Sulfate 325mg -Divalproex Sod Dr 500mg -Haloperidol 1mg -Losartan-Hydrochlorothiazide 50-12.5mg -Metoprolol Tartrate 25mg -Olanzapine 20mg -Xigduo XR 10mg	ROVIDER OR SUPPLIER RATR RESIDENTIAL FACILITY, INC RATR RESIDENTIAL FACILITY, INC REGULATORY OR LSC IDENTIFYING WIFORMATION) REGULATORY OR LSC IDENTIFYING WIFORMATION) Continued From page 3 -Admission date of 03/04/10, -Diagnoses of Moderate Intellectual Developmental Disorder, Unspecified Schizophrenia Spectrum. -The last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's record revealed; -49 year old maleAdmission date of 12/03/06Diagnoses of Schizoaffective Disorder, Bipolar TypeThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's record revealed; -49 year old maleAdmission date of 12/03/06Diagnoses of Schizoaffective Disorder, Bipolar TypeThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Admission date of 12/03/06Diagnoses of Schizoaffective Disorder, Bipolar TypeThe last drug regimen review completed was 03/30/22. Review on 01/25/23 of client #4's January 2023 Medication Administration Record (MAR) revealed the following medication regimen: -Chanitx img -Atorvastatin 20mg -Dilitazem 24h 360mg -Ferrous Sulfate 325mg -Divalprex Sod Dr 500mg -Haloperidol 1mg -Losartan-Hydrochlorothiazide 50-12.5mg -Metoprolol Tartate 25mg -Olanzapine 20mg -Xigduo XR 10mg	MHL026-822 STREET ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TARK RESIDENTIAL FACILITY, INC TABLE ADDRESS, CITY, STATE, ZIP CODE TABLE ADDRESS ADDRESS, CITY, STATE, ZIP CODE TABLE ADDRESS TABLE ADDRESS, CITY, STATE, ZIP CODE TABLE ADDRESS TABLE ADDRESS ADDRESS TABLE ADDRE

Division of Health Service Regulation

STATE FORM S5IT11 If continuation sheet 4 of 8

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L COMPLET		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		MHL026-822	B. WING	R 		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
EDEQU QT	ART RESIDENTIAL FAC	7866 AD	RIAN DRIVE			
FRESH 31	ART RESIDENTIAL FAC	FAYETTI	EVILLE, NC 283	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPL	LETE
V 121	Continued From page	4	V 121			
	-He would contact the drug regimen reviews	pharmacy and ensure the were completed.				
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					
V 289	27G .5601 Supervised	d Living - Scope	V 289			
	provides residential se home environment where the services is the content of the services of the s	is a 24-hour facility which ervices to individuals in a here the primary purpose of care, habilitation or duals who have a mental tal disability or disabilities, disorder, and who require he residence. If a facility shall be licensed if er: I minor clients; or adult clients. It is shall not reside in the secific population as tion means a facility which primary diagnosis is mental ave other diagnoses; tion means a facility which primary diagnosis is a ity but may also have other tion means a facility which primary diagnosis is a ity but may also have other tion means a facility which primary diagnosis is a ity but may also have other tion means a facility which primary diagnosis is a ity but may also have other tion means a facility which or means a facility which				

Division of Health Service Regulation

STATE FORM S5IT11 If continuation sheet 5 of 8

PRINTED: 02/12/2023 FORM APPROVED

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _	A. BUILDING:	
		MHL026-822	B. WING		R 01/26/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
FRESH ST	TART RESIDENTIAL FAC	ILITY INC. 7866 ADR	RIAN DRIVE		
		FAYETTE	VILLE, NC 2831	14	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
V 289	Continued From page	e 5	V 289		
	substance abuse depother diagnoses; (5) "E" designal serves adults whose substance abuse depother diagnoses; or (6) "F" designal private residence, which three adult clients who mental illness but maidisabilities, or three a clients whose primary developmental disabilities who family provides the seexempt from the follo .0201 (a)(1),(2),(3),(4 (A),(B),(E),(F),(G),(H),(18) and (b); 10A NCAC 27G .0208 (b),(e); 10 non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This factories	tion means a facility which primary diagnosis is sendency but may also have tion means a facility in a ich serves no more than ose primary diagnoses is y also have other dult clients or three minor y diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G			
	failed to operate within serving one of three a	as evidenced by: ew and interview, the facility n the scope of licensure by audited clients (#4) without a Developmental Disability.			
	Review on 01/25/23 of	of Division of Health Service			

Division of Health Service Regulation

STATE FORM S5IT11 If continuation sheet 6 of 8

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		SURVEY PLETED
			7 BOILBING			R
		MHL026-822	B. WING		01	/26/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
FRESH ST	TART RESIDENTIAL FAC	ILITY, INC	DRIAN DRIVE			
		FAYET	TEVILLE, NC 2831			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 289	Continued From page	e 6	V 289			
	licensed under 10A N	ecords revealed the facility is ICAC 27G .5600C Adults with Developmental				
	the waiver had expire	of DHSR records revealed and 12/31/2022 for client #4 to writhout a primary diagnosis of illity.				
	Review on 01/25/23 or revealed: - 49 year old male Admission date of 1 - Diagnoses of Schizo Type and Diabetes No Developmental I	2/03/06. paffective Disorder-Bipolar				
	 He had applied for a reside at the facility. He completed the wa 2022 and he thought 	the Licensee revealed: a waiver for client #4 to aiver at the beginning of the waiver was still good. itutes a re-cited deficiency d within 30 days.				
∨ 736	10A NCAC 27G .0303 EXTERIOR REQUIR (c) Each facility and it maintained in a safe,	EMENTS	V 736			

Division of Health Service Regulation

STATE FORM S5IT11 If continuation sheet 7 of 8

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7866 ADRIAN DRIVE FAYETTEVILLE, NC 28314 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 7 This Rule is not met as evidenced by: Based on observations and interview the facility was not maintained in a safe, clean, and attractive manner. The findings are: Observation on 01/25/23 at approximately 10:00am revealed: -A bed frame was laying against the wall of client #4's bedroomA blind in the sitting TV area the slates of a blind were brokenThe bathroom in client #5's the top of the toilet		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FRESH START RESIDENTIAL FACILITY, INC TRESH START RESIDENTIAL FACILITY, INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 7 This Rule is not met as evidenced by: Based on observations and interview the facility was not maintained in a safe, clean, and attractive manner. The findings are: Observation on 01/25/23 at approximately 10:00am revealed: -A bed frame was laying against the wall of client #4's bedroomA blind in the sitting TV area the slates of a blind were broken.		MUI 026 822 B. WING		1			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 7 This Rule is not met as evidenced by: Based on observations and interview the facility was not maintained in a safe, clean, and attractive manner. The findings are: Observation on 01/25/23 at approximately 10:00am revealed: -A bed frame was laying against the wall of client #4's bedroomA blind in the sitting TV area the slates of a blind were broken.	NAME OF PROVIDER OR SUPPLIER STREET ADD 7866 ADRIA			AN DRIVE		1 0112	0/2020
This Rule is not met as evidenced by: Based on observations and interview the facility was not maintained in a safe, clean, and attractive manner. The findings are: Observation on 01/25/23 at approximately 10:00am revealed: -A bed frame was laying against the wall of client #4's bedroomA blind in the sitting TV area the slates of a blind were broken.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
was missing. -The bathroom mirror was discolored at the bottom of the mirror. -Client #1's bedroom had a hole in the wall and the ceiling fan did not have any blades and the light was flickering. -The hall bathroom the toilet was missing the top of the back of the toilet. -The bathtub was discolored. During interview on 01/25/23 the House Manager revealed: -Client #1 had been having a lot of behaviors that included destroying property in the home. -The home would be repaired and he would destroy it again. -Client #1 had an appointment with his doctor that day to discuss medication to assist with his behaviors.	V 736	This Rule is not met Based on observation was not maintained in attractive manner. The Observation on 01/25 10:00am revealed: -A bed frame was lay! #4's bedroom. -A blind in the sitting were broken. -The bathroom in clie was missing. -The bathroom mirror. -Client #1's bedroom the ceiling fan did not light was flickering. -The hall bathroom the of the back of the toile. -The bathtub was disc. During interview on 0 revealed: -Client #1 had been hincluded destroying p. -The home would be destroy it again. -Client #1 had an app day to discuss medical	as evidenced by: as and interview the facility a a safe, clean, and a findings are: 5/23 at approximately ing against the wall of client TV area the slates of a blind ant #5's the top of the toilet was discolored at the had a hole in the wall and thave any blades and the alter toilet was missing the top et. colored. 1/25/23 the House Manager aving a lot of behaviors that broperty in the home. repaired and he would cointment with his doctor that	V 736			

Division of Health Service Regulation

STATE FORM 8899 S5IT11 If continuation sheet 8 of 8