North Carolina Department of Health and Human Services
Division of Health Service Regulation • Mental Health Licensure and Certification Section

Control Form
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Keyed Date: 5/14/25

Date of Visit: 4/22/25 – 4/23/25 Date Complaint Received (if applicable):

Facility Name: Rollingwood

Provider Number: 34G188 MHL#: 041-087

FID Number: 922015

Survey Type	Document	Check
All	CMS 1539: Certification and Transmittal	
All	CMS 2567: Statement of Deficiencies/Plan of Correction	
All	CMS-IJ Template (if IJ cited)	
Complaint, Follow-Up	CMS 2567: Revisit Report (Now saved as 2567F for follow ups)	
Recert only	CMS 3070G: Survey Report Form (completed by facility)	
Recert only	DHSR 4146: Civil Rights Compliance Form	
Recert only	DHSR 4503: ICF-IID Application for Certification/Recertification	

DHSR Staff Name: Justin Foster Date: 5/14/25

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SJQM
Facility ID: 922015

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **34G188**
2.STATE VENDOR OR MEDICAID NO.
(L2) **346073**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROLLINGWOOD**
(L4) **4206 WEST FRIENDLY AVENUE**
(L5) **GREENSBORO, NC** (L6) **27405**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/25/2019**

6. DATE OF SURVEY **04/23/2025** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **11** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **6** (L18)
13.Total Certified Beds **6** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
				6
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Transmit; Recert Survey 04.23.2025

17. SURVEYOR SIGNATURE
Justin Foster
Date : 05/14/2025 (L19)

18. STATE SURVEY AGENCY APPROVAL
Alice Thomas 5/16/25
Date: 05/14/2025 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:
Yes

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/24/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/14/2025
(L33)

DETERMINATION APPROVAL

North Carolina Department of Health and Human Services
Division of Health Service Regulation • Mental Health Licensure and Certification Section

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Application for Certification/Recertification in Title XIX (Medicaid) Program

Please print or type. Put an asterisk (*) beside the mailing address which reports from DHSR/Certification are to be forwarded.
If additional space is needed for any part, please identify and write on the back of this form.

Facility Information

Facility Name: RHA Health Services LLC-Rollingwood (identify facility as it is known or will be known)		MHL#: 041-087
Facility address (exact location, no PO box): 4206 W. Friendly Ave		
City: Greensboro	State: NC	ZIP: 27410
Telephone (including area code): 336-273-6105	County: Guilford	
Facility Administrator Name: Shelia Shaw (if administrator is someone other than a person in the facility, give name and title of person responsible for daily operation)		
Email Address: sshaw@rhanet.org		
Anticipated Opening Date of New Facility: N/A		Number of Beds: N/A

Reminder: The Facility's effective date for participation in the Medicaid program cannot be prior to the on-site survey of either the general survey or the life safety code survey; whichever is the later survey date. If deficiencies are cited in either survey, the effective date cannot be prior to the date of an acceptable plan of correction received by DHSR. Before the general survey can be scheduled, the facility must be licensed, in operation and has clients which cannot be reimbursed by Medicaid prior to the effective date of certification.

Owner Information

Owner's Name: RHA Health Services LLC		
Corporate Administrator (name & title): Mickey Atkins		
Business address: 17 Church St		
City: Asheville	State: NC	ZIP: 28801
Telephone (including area code): 828-232-6844		

Management Company Information

(If facility is managed by a firm or someone other than owner, complete this section)

Management Company Name: RHA Health Services LLC		
Address: 17 Church St		
City: Ashville	State: NC	ZIP: 28801
Telephone (including area code): 828-232-6844		

Day Program Information

Day Program Facility Name: Gatewood Voc (identify facility as it is known or will be known)		MHL#:
Address: 1508 Gatewood Ave		
City: Greensboro	State: NC	ZIP: 27405
Telephone (including area code): 336-273-6105		

Signature/Date: Mellisa White, QP	4/22/25
Printed Name and Title: Mellisa White, QP	

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

Form Approved
OMB No. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES
SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code
RHA Health Service LLC - Bellingwood	4206 W. Friendly Ave	Greensboro Guilford	NC	27410

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No
34160073	Mikey Atkins	828-232-6844 W1

9. State/Region code	10. State/County code	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5
04 W2	34 W3	4/22/25	4/23/25

12. Type of Ownership or Control (enter number in box below)

2 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other (specify) _____ W8

13. Is this ICF/IID a distinct part of a Hospital, SNF or NF?

☐ Yes ☒ No W7

14. If "Yes" to block 13, indicate either

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. W8

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QIDP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker	2	2
G. LSC Specialist	1	0
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify)		
N. Total number of Surveyors onsite W13	0	3
O. Total number of QIDP Surveyors onsite W12	0	2

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel W23 (483.430(d)(3))	10.00
B. Registered Nurse W24 (483.480(d)(3))	.25
C. Licensed Voc./Practical Nurse W25 (483.480(d)(2))	.25
D. Total Personnel W26 (List the Full Time Equivalent for all employees)	10.50

16. Facility Data

A. Is this ICF/IID a residential unit within a larger organization or agency in the State that provides residential services to individuals with intellectual disabilities? (check one) ☒ Yes ☐ No
If "No", proceed to item C. W13

B. If "Yes," indicate name and address of larger organization.

Name RHA Health Services LLC - moved to Bellingwood

Address 17 Church St

City Ashville State NC ZIP Code 28801

Name of CEO Mikey Atkins

Total Number of Beds W14	1029
Total Number of Clients (including ICF/IID clients directly served) W15	1018
C. Total Number of ICF/IID Clients W16	006
D. Is this ICF/IID community-based? (check one) W17	☑ Yes ☐ No
E. Total number of ICF/IID beds under this Provider No W18	006
F. Total number of discrete living units under this Provider No. W19	001
G. Age range of clients served from W20 44 to W21 70	
H. Total number of off-campus day program sites used by ICF/IID clients W22	01

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs? W27	004
B. In how many off-campus day program sites was an observation done by the Surveyor? W28	000

20. Individual Characteristics (Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)

A.

(1) Age

under 22(a)	0	W29
22-45 (b)	1	W30
46-65 (c)	4	W31
66+ (d)	1	W32
Total	6	W33

(2) SEX

Male	6	W34
Female	0	W35
Total	6	W36

B. DISABILITIES

(1) Intellectual Disability

Mild	0	W37
Moderate	2	W38
Severe	4	W39
Profound	0	W40
Total	6	W41

(2) Autism	1	W42
(3) Cerebral Palsy	2	W43
(4) Epilepsy	multiple	
Controlled	2	W44
Uncontrolled	0	W45
Total	2	W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile	3	W47
Non-Mobile	0	W48
Total	3	W49

(2) Speech/Language Impairment	3	W50

(3) Hearing Impairment

Hard of Hearing	0	W51
Deaf	0	W52
Total	0	W53

(4) Visual Impairment

Impaired	3	W54
Blind	0	W55
Total	3	W56

D. MEDICAL CARE PLAN	0	W57
E. DRUGS TO CONTROL BEHAVIOR	4	W58
F. PHYSICAL RESTRAINTS	0	W59
G. TIME-OUT ROOMS	0	W60
H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	0	W61
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	6	W62
J. NUMBER OF COURT ORDERED ADMISSIONS	0	W63
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	0	W64

L. OTHER (specify)

(1)	0	W65
(2)	0	W66
(3)	0	W67

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES SURVEY REPORT

M. ALLEGATIONS OF ABUSE AND NEGLECT		
no. of allegations of abuse investigated (a)	0	W68
no. of allegations of neglect investigated (b)	0	W69
Total	0	W70

N. NUMBER OF DEATHS		
no. of deaths related to unusual incidents (a)	0	W71
no. of deaths related to restraints (b)	0	W72
no. of deaths for any reason (c)	1	W73
Total	1	W74

ALLEGATIONS OF ABUSE AND NEGLECT AND NUMBER OF DEATHS
DATA ENTRY INSTRUCTIONS

M. Allegation of abuse and neglect

(W68) Number of allegations of abuse investigated.
(W69) Number of allegation of neglect investigated.

According to 42CFR §488.301:

Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Consistent with the referenced definitions, enter the number of allegations of abuse and or neglect investigated, including investigations resulting from complaints, follow ups, initials or recertifications.

If there is no information to report, leave the field blank.

(W70) Total
This field represents a combined total of W68 (allegations of abuse investigated) and W69 (allegations of neglect investigated). The total for this field is program generated therefore, no data input is necessary.

N. Number of Deaths

(W71) Number of deaths related to unusual incidents.
Insert the number of deaths that occurred as a result of unusual incidents. This includes all unexpected or unanticipated deaths not included in W72 or W73.

(W72) Number of death related to restraints.
Insert the number of deaths that occurred as a result of the use of restraints.

(W73) Number of deaths for any reason.
Insert the number of deaths occurring for any reason. Do not include information contained is W71 and W72 above.

(W74) Total
This field represents a combined total of W71 (number of deaths related to unusual incidents), W72 (number of deaths related to restraints), and W73 (number of deaths for any reason).
The total for this field is program generated; therefore, no data input is necessary.

CIVIL RIGHTS (Title VI) COMPLIANCE FORM

Date of Visit: 4/22/25 – 4/23/25

Facility Name: Rollingwood

Licensee: RHA Health Services NC, LLC

Site Address: 4206 W. Friendly Ave, Greensboro, NC 27410

Provider Number: 34G188 MHL#: 041-087 Phone:

Yes	No	N/A	Materials Reviewed	Explanation (if needed)
X			The facility's policies and procedures are consistent with Title VI requirements	
X			Room assignments are made on a random basis.	
X			All areas appear to be used by all races in the same manner.	
X			On the day of the visit, the above referenced facility was found to be in compliance with Title VI.	

Comments:

DHSR Staff Signature: Chad Sprehe /s/

Date: 4/28/25

CC: Facility File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G188	A. BUILDING _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD	4206 WEST FRIENDLY AVENUE GREENSBORO, NC 27405

(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)	(X5) COMPLETION DATE
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure staff were sufficiently trained to perform his or her duties for 3 of 4 audited clients (#3, #4 and #6). The findings are: A. The facility failed to ensure safe movement of client #3's wheelchair in the home. For example: Observations in the group home on 4/23/25 at 8:04 AM revealed staff E to move client #3 in his wheelchair without his permission from the front entryway to the living room. Continued observation revealed staff E to push client #3's wheelchair into two wooden chairs, enough to clear an opening to get him through to the living room. Interview with the qualified intellectual disabilities professional (QIDP) on 4/23/25 confirmed staff receive training on client rights, inluding the right to be treated with dignity and respect. Further interview with the QIDP revealed staff E should have moved the wooden chairs rather than push client #3's wheelchair into them. B. The facility failed to ensure client #4 had safe access to his environment. For example: Observations in the group home on 4/23/25 at 8:07 AM revealed staff E to forcefully ambulate client #4 without his permission to the kitchen sink to wash his hands and to set his place at the	W 189	W 189 A-C The QP will obtain re-evaluations from the physical therapist to clarify specific recommendations for ambulation for clients #4, and #6. Staff will be in-serviced by the QP on appropriate methods to assist all people supported at Rollingwood with ambulating based on the recommendations of the Physical Therapist and ensuring dignity and respect. This will be monitored by the clinical team through unannounced observations at least twice a week for a period of one month. In the future, the QP will ensure the people supported are assisted with ambulation in both the recommended manner and with dignity and respect. RECEIVED DHSR-MH Licensure Sect	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

RP | 5/16/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G188	A. BUILDING _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD	4206 WEST FRIENDLY AVENUE GREENSBORO, NC 27405

(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)	(X5) COMPLETION DATE
W 189	Continued From page 1 table. Continued observation revealed staff E to dry client #4's hands as he walked away towards the living room. Further observation at 8:24 AM revealed staff E to forcefully ambulate client #4 again towards the kitchen sink to wash his hands and to set his place at the table. Further observation revealed staff E to limit client #4's movement to the immediate kitchen area. Interview with the QIDP on 4/23/25 confirmed staff receive training on client rights, including the right to be treated with dignity and respect. Further interview with the QIDP revealed staff E should not force or limit a client's movements. C. The facility failed to ensure client #6 had safe access to his environment. For example: Observation in the group home on 4/23/25 at 8:16 AM revealed staff E to grab client #6 under his arms and ambulate him to the kitchen to wash his hands without utilizing his gait belt. Continued observation at 8:19 AM revealed staff E to grab client #6 under his arms and ambulate him to the dining room table without utilizing his gait belt. Further observation at 8:29 AM revealed client #6 to nearly fall due to staff holding him up by his shoulders instead of utilizing his gait belt. Interview with the QIDP on 4/23/25 confirmed staff should utilize client #6's gait belt at all times as prescribed.	W 189		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G188	A. BUILDING _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD	4206 WEST FRIENDLY AVENUE GREENSBORO, NC 27405

(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)	(X5) COMPLETION DATE
W 249	Continued From page 2 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 4 audited clients (#6) received a continuous active treatment program consisting of needed interventions relative to their adaptive equipment. The finding is: Observations throughout the 4/22-23/25 survey revealed client #6 to wear a gait belt around his torso. Continued observations throughout the survey revealed multiple staff to support client #6 with ambulating, without utilizing his gait belt. Review of client #6's record on 4/23/25 revealed a physical therapy (PT) evaluation dated 2/5/25. Review of the PT evaluation indicated client #6 requires contact assist +1 for transfers and ambulates for functional mobility; continued supervision for gait is recommended due to a risk for falls secondary to decreased safety awareness; he wears a gait belt during waking hours to ensure his safety. Continued review of the PT evaluation revealed recommendations for client #6 to continue contact guard assist for safety during transfers, gait, and ADL's. A gait belt is used during waking hours. Interview with the qualified intellectual disabilities professional (QIDP) on 4/23/25 confirmed staff should utilize client #6's gait belt at all times as	W 249	W 249 The QP will obtain a re-evaluation from the Physical Therapist in order to clarify recommendations for ambulation for client #6. Staff will be in-serviced by the QP on recommended methods to assist client #6 as well as all people supported at Rollingwood with ambulating based on the recommendations of the Physical Therapist and ensuring dignity and respect. This will be monitored by the clinical team through unannounced observations at least twice a week for a period of one month. In the future, the QP will ensure the people supported are assisted with ambulation in both the recommended manner and with dignity and respect.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G188	A. BUILDING _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD	4206 WEST FRIENDLY AVENUE GREENSBORO, NC 27405

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W 249	Continued From page 3 prescribed.	W 249		