

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

ORIGINAL

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025
---	---

(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
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/27/15 through 7/29/15. Prairie Estates Healthcare Community was found not in compliance with the following requirements: F176 and F441.	F 000	<i>Addendums noted with an asterisk per 9/2/15 telephone to facility administrator JVE/SAACH/JJ</i> F 176 Resident Self-Administer Drugs if Deemed Safe	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to do an assessment and obtain physician's orders for self administration of a medication delivered by a nebulizer (machine that turns a liquid medication into a mist to breath in) for two of two observed residents (11 and 12) by one of one registered nurse (RN) (A). Findings include: 1. Observation and interview with RN A on 7/28/15 at 9:40 a.m. as he administered a nebulizer treatment to resident 11 revealed he: *Set-up and started the nebulizer treatment for the resident. *Told the resident he would return in ten minutes and left the room. *Stated they did not stay with the residents who	F 176	Observation 1: Resident # 11 has been given a self-administration of medication evaluation and a doctor's order to self-administer the nebulizer treatment has been received. Observation 2: Resident # 12 has been given a self-administration of medication evaluation and a doctor's order to self-administer the nebulizer treatment has been received. All other resident who are ordered nebulizer treatments or desire to self-administer their own medications have been reviewed and a self-administration of medication evaluation has been administered and a physician's order has been obtained if necessary. The Director of Nursing and the Pharmacy Consultant have reviewed the self-administration of medication and self-administration of medication assessment as of 8-14-2015. Nursing staff have been reeducated on the policy and procedure regarding self-administration of medication as of 8-20-2015.	8-27-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl Hallaway, Administrator</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/21/2015</i>
--	-------------------------------	-------------------------------

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.

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015	
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
(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
F 176	<p>Continued From page 1</p> <p>were alert and oriented during the nebulizer treatments. *But if a resident was confused or would take the mask off they would stay with the resident during the treatment.</p> <p>2. Observation on 7/28/15 at 9:48 a.m. with RN A as he administered a nebulizer treatment to resident 12 revealed he: *Set-up and started the nebulizer treatment for the resident and left the room. *Told the resident he would return in ten minutes.</p> <p>3. Interview on 7/29/15 at 4:37 p.m. with the director of nursing (DON) with RN B present revealed the DON agreed a: *Resident assessment should have been completed to ensure the resident was capable to handling the nebulizer administration without a nurse present. *Physician's order should have been written allowing the resident to self-administer the nebulizer medication administration after set-up.</p> <p>Review of residents' 11's and 12's medical records revealed there were no: *Assessments for self-administration of medications. *Physician's orders for self-administration of medications.</p> <p>Review of the provider's August 2013 Self-Administration of Medications policy revealed: *If the resident had expressed a desire to self-administer a medication the interdisciplinary team would assess the resident's cognitive, physical, and visual ability to carry out that responsibility.</p>	F 176	<p>The Director of Nursing will monitor those residents ordered nebulizer treatments and or those whom have the desire to self-administer their medications to ensure an evaluation has been completed and a physician order is completed. The [REDACTED] [REDACTED] monthly x 3 months and then quarterly thereafter to ensure compliance is being met or if further interventions are needed. The Director of Nursing will report her findings to the QA committee monthly.</p> <p>Completion Date: 8-27-2015 Monitored by the Director of Nursing</p> <p><i>DON will monitor all residents that do nebs or self-administer nebs</i></p> <p><i>JVE/SODAH/JJ</i></p>	<p>* [REDACTED]</p> <p><i>JVE/DAH/JJ</i></p>

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
(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	
F 176	Continued From page 2 *If the resident was found to be capable of self-administration nursing was to get an order from the physician for self-administration of the medication. *A review of the self-administration of medication process was to occur at quarterly care conferences.	F 176	F 441 Infection Control Actions noted in observation #1 Provide proper sanitizing and disinfecting of the whirlpool.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	Proper sanitizer and disinfectant had been placed in the whirlpool on 7-29-2015 to ensure proper ratio of sanitizer to water for effective disinfecting of the whirlpool. The Policy and Procedure for cleaning and disinfection of the whirlpool has been reviewed and revised as of 7-30-2015. The Maintenance Supervisor and staff have been reeducated individual as of 8-10-2015 and will be as a group on 8-25-2015 regarding proper procedure for cleaning the whirlpool and to ensure the proper ratio of disinfecting chemical is being used in the whirlpool to prevent cross contamination. The Director of Nursing, Administrator, and Maintenance Supervisor will monitor at least 10 of the baths and the sanitizing and disinfecting of the whirlpool weekly x 4 weeks, and then at least 20 of baths given monthly to ensure proper sanitizing and disinfecting chemical	8.27.15	

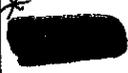
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
(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
F 441	<p>Continued From page 3 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, manufacturers' instructions review, provider instructions review, and policy review, the provider failed to disinfect one of one whirlpool tub according to manufacturers' instructions. Findings include:</p> <p>1. Observation and interview with certified nursing assistant (CNA) C on 7/28/15 at 3:00 p.m. while cleaning the whirlpool tub after use revealed she:</p> <ul style="list-style-type: none"> *Put goggles and gloves on. *Filled the bottom well of the whirlpool tub with water. *Put in one cup full of Classic Whirlpool Disinfectant Cleaner. *Started the whirlpool jets and let them run for fifteen seconds. *Brushed the entire tub and tub chair and all parts with a scrub brush. *Opened the drain. *Rinsed the scrub brush, the tub, chair, and all parts with water. *Filled the bottom tub well with water then turned on jets. She repeated that process until the water was clear of bubbles. *Stated that was the procedure she had been taught to clean the whirlpool tub jets after use. 	F 441	<p>and procedure is being performed and the Administrator will report the findings to the QA committee monthly. The Director of Nursing will continue to monitor for occurrence of infection and control breakouts using the current recording tool to determine trends and she will report the findings to the QA committee monthly.</p> <p>Completion date: 8-27-2015 Monitored by: Director of Nursing, Administrator, and Maintenance Supervisor</p>	<p><i>JVE/SMO/H/JJ</i></p>

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
(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
F 441	<p>Continued From page 4</p> <p>2. Observation and interview with CNA C on 7/29/15 at 3:15 p.m. again in the whirlpool tub room revealed: *She stated the automatic disinfectant fill feature of the whirlpool tub had not worked as long as she remembered. *It took six gallons of water to fill the bottom well of the whirlpool tub when measured out gallon by gallon. *She stated she was taught to fill the bottom well of the whirlpool tub and to use one cup of Classic Whirlpool Disinfectant Cleaner.</p> <p>Interview on 7/29/15 at 4:37 p.m. with the director of nurses (DON) with registered nurse B present revealed: *The automatic disinfectant fill feature of the whirlpool tub had not been working for about a year. *The DON agreed the whirlpool tub had not been disinfected according to manufacturer's instructions.</p> <p>Review of the provider's October, 2014 Tub (Whirlpool)/Shower Cleaning policy revealed the tub should have been cleaned with the tub manufacturer's recommended disinfectant solution.</p> <p>Review of the disinfectant manufacturer's instructions revealed there should have been: *Two ounces of Classic Whirlpool Disinfectant Cleaner solution mixed with each gallon of water. *One and a half cups added to the whirlpool tub's bottom well which held six gallons of water.</p> <p>Review of the provider's undated instructions for Disinfection/Sanitizing the Whirlpool Tub posted on the wall of the whirlpool tub room revealed:</p>	F 441		<p>*  JWEISS/SAH/JJ</p>

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025
---	---

(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
--------------------	--	---------------	---	----------------------

F 441	Continued From page 5 *They were to fill the tub with four gallons of water to cover just the lower jet in the bottom well of the tub. *Then they were to add one cup (eight ounces of Classic Whirlpool Disinfectant Cleaner into the water. *Then turn on the whirlpool jets and run until solution flows out of all jets, then shut it off.	F 441		*  JUE/5000H/JJ
-------	---	-------	--	--

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

ORIGINAL

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025
---	---

(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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/28/15. Prairie Estates Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/28/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 032 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor of the building. Two of three basement exits (boiler room and laundry room) did not meet the standard for a means of egress.</p>	K 032		"F"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cherilyn Hallaway</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/21/15</i>
---	-------------------------------	-----------------------------

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.

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
(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
K 032	<p>Continued From page 1</p> <p>The deficient practice affected one of one smoke compartment and staff. Findings include:</p> <p>1. Observation at 11:00 a.m. on 7/28/15 revealed the basement was not provided with two approved means of egress. The boiler room and the laundry room exits were through a hazardous area. Review of previous survey data indicated that condition had existed since the original construction.</p> <p>This deficiency would have no effect on resident safety.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 032		"F"

ORIGINAL

PRINTED: 08/11/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	---	---	--

NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 600 S FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/27/15 through 7/29/15. Prairie Estates Healthcare Community was found in compliance.	S 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cheryl Hallaway

TITLE

Administrator

(X6) DATE

8/21/15

STATE FORM

6899

ULDN11

If continuation sheet 1 of 1

