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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

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F 000	INITIAL COMMENTS Correction date: 8/24/2019 The following information relates to the annual health survey. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Burnett — TITLE: Administrator — (X6) DATE: 8/9/2019

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.

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to treat each resident with dignity and respect in a manner and environment that promotes maintenance or enhancement of quality of life, recognizing each resident's individuality for 4 of 4sampled (Resident #5, #9, #11 and #17). The facility reported a census of 20. Findings included: 1. The Minimum Data Set (MDS) assessment dated 7/3/19 documented Resident #17 had diagnoses of Alzheimer's, psychotic disorder, and schizophrenia. The MDS revealed Resident #17 had severe cognitive impairments. The MDS dated 7/3/19 revealed Resident #17required limited assistance of one staff for transfers and extensive assistance of one staff for bed mobility, dressing, toilet use, personal hygiene, and bathing. The Care Plan dated 8/28/18 documented Resident #17 had dementia and delusional disorder and directed staff to provide comfort and support while diverting conversation. During an observation on 7/23/19 at 8:27 a.m.,	F 550		

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F 550	Continued From page 2 Resident #17 picked up her bowl of cereal off the table. Staff A (Registered Nurse) abruptly stated, "Put it back on the table". Staff A spoke in a harsh manner. Resident #17 stated, "stop that" to another resident. Staff A bluntly stated to Resident #17, "She's fine". During an observation on 7/23/19 at 12:00 p.m., revealed Resident #17 greeted Staff A as she walked out of the dining room. Staff A loudly stated to Staff C (Registered Nurse), "She is not as bossy today". Other residents sat in the immediate vicinity. 2. The MDS assessment dated 6/28/19 documented Resident #9 had diagnoses of Alzheimer's dementia, senile degeneration of the brain, and need for assistance with personal care. Resident #9 had severe cognitive impairments. The MDS dated 6/28/19 revealed Resident #9 required extensive assistance of one staff for bathing, and extensive assistance of two staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene. During an observation on 7/23/19 at 11:00 a.m., Resident #9 exited his room wearing a mismatched outfit. Staff A looked at the resident and stated loudly, "Did you dress yourself"? Other residents and the surveyor were within earshot of Staff A's comment. During an interview on 7/24/19 at 8:14 a.m., the Director of Nursing reported Staff A did not approach the residents appropriately at times. The Director of Nurses reported Staff A was new and did not complete the dementia training. 3. Observation during meal service on 7/22/19 at 12:00 p.m. revealed Staff A (Registered Nurse)	F 550		

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F 550	Continued From page 3 approached Resident #11 with medications. Staff A repeatedly told Resident #11 to take her medications in an abrasive manner. Resident #11 refused the medications. Staff A walked back to the medication cart. Staff A approached Resident #11 again. Staff A, in an undignified manner, told Resident #11 to take her medications as she put the spoon up to Resident #11's mouth. Resident #11 refused to open her mouth. Staff A kept the spoon up to Resident #11's mouth. Staff A continued to tell Resident #11 to take her medications. Staff A repeated this three times until Resident #11 took a small bite of the applesauce. Staff A walked with applesauce on the spoon. 4. Observation on 7/22/19 at 10:55 a.m., revealed Staff A entered Resident #5's room with medications. Staff A failed to knock prior to entering the room. Staff A checked on Resident #5 multiple times and failed to knock on the door prior to entering Resident #5's room. During an interview on 7/24/19 at 8:30 a.m., the Director of Nursing stated an expectation of staff to knock and announce their name prior to entering the resident's room. The Resident's Rights policy dated 11/28/16 directed the staff to treat residents with consideration, respect, and dignity in recognition of individuality and preferences.	F 550		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

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F 658	Continued From page 4 This Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed administer medications according to professional standards of practice for 3 of 7 sampled (Residents #11, #15, and #19) and 5 residents observed during meal service. The facility reported a census of 20. Findings included: 1. The Minimum Data Set (MDS) assessment dated 6/30/19 documented Resident #19 had diagnoses of non-Alzheimer's dementia, cognitive communication deficit, and wandering. Resident #19 had severe cognitive impairments. The Care plan dated 6/20/19 revealed Resident #19 had had short and long-term memory loss and directed the staff to provide orientation. During an observation on 7/22/19 at 8:00 a.m., Staff A (Registered Nurse) placed Resident #19's medications in a cup. Staff A handed the cup to Resident #19 and walked back to the medication cart. Resident #19 placed all of the medications on a napkin and took them while Staff A looked at the computer screen. Staff A failed to observe Resident #19 take any of the medications. 2. The MDS assessment dated 5/13/19 documented Resident #11 had diagnoses of Alzheimer's disease, psychotic disorder, and schizophrenia. Resident #11 had severe cognitive impairments. During an observation on 7/22/19 at 8:17 a.m., Staff A mixed 1 teaspoon of Metamucil with water. Staff A administered Resident #11's medications	F 658		

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F 658	Continued From page 5 and left the Metamucil on the dining table. Staff A directed Resident #11 to drink the Metamucil with her breakfast. Staff A walked back to the medication cart. At 8:22 a.m., Staff A stirred the Metamucil. Staff A left the dining room and returned. At 8:26 a.m., Staff A approached Resident #11 and asked her if she was in any pain. Resident continued to eat. Staff D (Registered Nurse) approached Resident #11. Resident #11 started to drink the Metamucil. Staff D stirred the Metamucil and Resident #11 finished drinking it. The Metamucil label directed staff to mix with water, stir briskly, and drink promptly, and if mixture thickened, add more liquid and stir. 3. Observation during meal service on 7/23/19 at 11:53 a.m. revealed Staff A (Registered Nurse) and Staff C (Registered Nurse) at the medication cart. Staff C emptied the contents of a medication packet into a medication cup. Staff A stated she would give the medication. Staff A proceeded to administer the medications. Staff A did not set up the medications and did not review the Medication Administration Record prior to administering the medications. Staff C prepared the medications for two more residents and Staff A administered the medications. 4. The MDS assessment dated 6/19/19 documented Resident #15 had diagnoses of diabetes, anxiety, and psychotic disorder. Resident #15 had severe cognitive impairments. During an observation on 7/23/19 at 1:00 p.m., Staff C (Registered Nurse) stated Resident #15 had a blood glucose level of 181 milligrams per deciliter. Staff C administered two units of Novo log insulin with a Flex pen. Staff A failed to prime	F 658		

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F 658	Continued From page 6 the pen and waste two units prior to injecting the insulin. Staff C stated the staff only time the staff prime the pen is when the pen is new prior to the first use. The Insulin Administration policy dated 11/28/17 failed to direct the staff to prime insulin pens prior to each use. The official Novo log Flex pen insert, located at www.novo-pi.com/novolog, instructed staff to prime the pen with two units prior to each injection to avoid injecting air and to ensure proper dosing. During an interview on 7/24/19 at 8:14 a.m., the Director of Nursing stated she expected the nurses to watch residents consume their medications. She stated it was okay for another nurse to administer a medication they did not set up as long as the first nurse made sure everything was okay. The Director of Nurses stated the pharmacy informed the facility they only had to prime the insulin pens prior to the pen's first use, not with each use. During an interview on 7/24/19 at approximately 9:00 a.m., the Administrator confirmed the facility did not have a policy for Medication Administration. 5. Observations during meal service on 7/22/19 at 11:49 a.m. revealed Staff A (Registered Nurse) administered medications to two residents. Staff A left the medications on the table and walked away. Staff A continued her medication pass without observing the two residents to ensure they took their medications.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 7 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed safely transport a resident in a wheelchair for 1 of 4 sampled (Resident #16). The facility reported a census of 20. Findings included: 1. The Minimum Data Set (MDS) assessment dated 4/29/19 documented Resident #16 had diagnoses of Alzheimer's, arthritis, and difficulty walking. Resident #16 had severe cognitive impairments. The MDS dated 4/29/19 revealed Resident #16 required extensive assistance of one staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. During an observation on 7/21/19 at 1:00 p.m., Staff B (Nursing Aide) pushed Resident #16 in a wheelchair from the nurse's station to Resident #16's room. Resident #16 held her legs up. Staff B failed to transport Resident #16 with foot pedals in place. Staff B pushed Resident #16 15 steps. During an interview on 7/24/19 at 8:14 a.m., the Director of Nurses reported an expectation of staff to utilize foot pedals when pushing residents in a wheelchair.	F 689		

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F 689	Continued From page 8 During an interview on 7/24/19 at approximately 9:00 a.m., the Administrator stated he did not currently have a policy on foot pedals but would search further.	F 689		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This Requirement is not met as evidenced by: Based on record review and interviews the failed to use the services of a Registered Nurse for 8 consecutive hours a day, 7 days a week. The facility reported a census of 20. Findings included: Review of the staffing schedule for June 2019 revealed the facility failed to utilize a Registered Nurse for 8 hours on June 22, 2019 and June 23, 2019. During an interview on 7/23/19 at 4:32 p.m., the Director of Nurses confirmed the facility failed to utilize a Registered Nurse on June 22nd and 23rd.	F 727		
F 803	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		

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F 803 SS=D	Continued From page 9 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview the facility to serve meals according to the planned menu for 1 of 2 sampled on a pureed diet. The facility reported a census of 20. Findings included: On 7/21/19, the Dietary Manager reported two residents received puree diets. The planned menu for 7/21/19 included the	F 803		

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F 803	Continued From page 10 following for puree diets: a. 1 serving spaghetti and meat sauce b. tossed greens and dressing c. garlic bread d. triple fudge brownie Observation on 7/22/19 at 11:45 a.m. revealed the Dietary Manager pureed three servings of spaghetti noodles, sauce, 18 meatballs, and 3 slices of garlic bread with chicken broth. Observation revealed the meal served ended on 7/22/19 at 12:32 p.m. All of the pureed garlic bread remained in a pan in the steam table. The Dietary Manager reported one of the two residents on a pureed diet refused a meal tray. Observation of the one pureed diet served to a resident in the dining room revealed the staff failed to serve the pureed garlic bread. During a staff interview on 7/23/19 at 2:43 p.m., the Dietary Manager reported she forgot to serve the puree garlic bread.	F 803		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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F 812	Continued From page 11 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This Requirement is not met as evidenced by: Based on observation and staff interview the facility failed to serve food in accordance with professional standards for food service safety for 1 of 1 meal observed. The facility reported a census of 20. Findings included: Observation of the lunch meal service on 7/22/19 revealed the Dietary Manager checked the temperature of the ground meatballs, puree garlic bread and puree meatballs with a thermometer. The Dietary Manager used the same alcohol prep pad to sanitize the thermometer between each food item. The ground meatballs did not heat to the appropriate temperature and had to be reheated. During a staff interview on 7/23/19 at 2:43 p.m., the Dietary Manager stated she thought she used a new alcohol wipe for each food item.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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F 880	Continued From page 12 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

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F 880	Continued From page 13 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: Based on observations and staff interview the facility failed to perform appropriate hand hygiene during medication pass for two residents. The facility reported a census of 20. Findings included: Observation of meal service on 7/22/19 at 11:49 a.m., revealed Staff A (Registered Nurse) administered medications with applesauce to a resident with a spoon. Staff A, then administered medications to another resident. Staff A failed to perform hand hygiene between each resident. During an interview on 7/24/19 at 8:28 a.m., the Director of Nurses stated an expectation of staff to use sanitizing hand gel between each resident.	F 880		

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F 550 Resident Rights/Exercise of Rights CFR(s) 483.10(a)(1)(2) (b)(1)(2)

The facility does provide the residents their rights to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including but not limited to treating each resident with respect and dignity.

Residents 5, 9, 11, and 17 were affected with. All residents have the potential to be similarly affected.

The facility will ensure that new hires complete the following before starting orientation:

a. Dependent Adult Abuse and Mandatory Reporter course
b. Dementia Training Course "Hand in Hand" from Health Care Academy (6 CEUs)

The facility updated the new hire checklist to ensure that new staff receive the trainings mentioned above while in orientation.

The facility will ensure that current employees complete the trainings listed above by 8/24/2019.

The facility held an in-service on 8/8/19 to educate all staff on resident rights with an emphasis on treating residents professionally with respect and dignity.

An audit form will be used to interview staff and residents on staff to resident communications and interactions.

An audit will be completed by the Administrator or designee weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

The interdisciplinary team (QA) will review all new hires and current employees to ensure that they receive the trainings listed above.

Responsible party - Administrator

Compliance Date – 8/24/2019

F 658 Services Provided Meet Professional Standards CFR(s) 483.21 (b)(3)(i)

The facility does provide the services provided or arranged by the facility, as outlined by the comprehensive care plan and does meet professional standards of quality.

Residents 11, 15, and 19 were affected. All residents have the potential to be similarly affected.

The DON and ADON educated all LPNs and RNs on:

a) The Medication Administration policy, including the "rights" of medication administration and preparing and administering medications according to professional standards.
b) The Insulin Pens policy and procedure which was updated on 8/5/19 to direct staff to prime insulin pens prior to each use.

The DON and ADON audited all LPNs and RNs immediately within their next scheduled shift on medication administration by utilizing a comprehensive audit tool.

Additionally, the same audit for medication administration will be completed by the Director of Nursing and/or designee weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

Responsible party - DON

Compliance Date – 8/24/2019

F 689 Free of Accident Hazards/Supervision/Devices CFR(s) 483.25(d)(1)(2)

The facility does provide our residents an environment free of accident hazards as is possible, adequate supervision and assistance devices to prevent accidents.

Resident 16 was affected with no harm committed.

The facility will utilize wheelchair bags (with supply on hand) to be used for storing foot pedals and miscellaneous resident items.

The facility held an in-service on 8/8/2019 to educate staff on the "Wheelchair Positioning and Mobility" policy and procedure.

An audit tool will be used to verify that staff are utilizing foot pedals appropriately.

Audit will be completed by the Administrator and/or designee weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

Responsible party - Administrator
Compliance Date – 8/24/2019

F 727 RN 8 Hrs/7 days/Wk, Full Time DON CFRs 483.35(b)(1)-(3)

The facility does use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

No residents affected.

The facility has recently hired 2 full time RNs and 1 PRN RN.

The facility will audit RN coverage during a morning stand-up meeting in the week before the start of a month.

Schedules will be completed monthly to include 8 hours of consecutive RN coverage.

Schedules will be audited daily and adjusted for changes to ensure 8 hours of consecutive RN coverage.

Responsible party - Administrator
Compliance Date – 8/24/19

F 803 Menus Meet Resident Needs/Prep in Adv/Followed CFR(s) 483.25(d)(1)(2)

The facility does ensure that menus meet the nutritional needs of residents in accordance with established national guidelines; be prepared in advance and be followed.

1 resident was affected. Residents with puree diets have the potential to be similarly affected. All residents have the potential to be similarly affected.

All dietary staff will be educated at in-service on 8/8/2019 regarding following the menu and ensuring that all menu items are served to all residents.

An audit tool will be used to verify that residents receive the correct menu items.

Audit to be conducted by the Administrator and/or designee three times weekly times two, weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

Responsible party - Administrator

Compliance Date – 8/24/2019

F 812 Food Procurement. Store/Prepare/Serve-Sanitary CFR(s) 483.260(i)(1)(2)

The facility does meet food safety requirements and does store, prepare, distribute and serve food in accordance with professional standards for food service safety.

No residents were affected with the potential to affect all residents.

All dietary staff will be educated at Inservice on 8/8/2019 to wipe the thermometer with 1 unused alcohol wipe in between all temperature checks.

The temperature check log has a new column listed at "Clean alcohol wipe used" to remind staff to disinfect the thermometer in between uses.

Audit will be conducted by the Administrator and/or Designee weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

Responsible party - Administrator
Compliance Date – 8/24/2019

F 880 Infection Prevention & Control Devices CFR(s) 483.80(a)(1)(2)(4)(e)(f)

The facility has established and will continue to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Infection prevention and control Written standards, policies, and procedures for the program, which must include, but are not limited to: The hand hygiene procedures to be followed by staff involved in direct resident contact.

No residents were affected with the potential to affect all residents.

The facility will hold an in-service on 8/8/2019 and will educate staff on hand hygiene and appropriate hand sanitizer use.

The DON or designee will utilize the medication administration audit tool to ensure proper hand hygiene during medication administration.

Audit will be conducted by the DON and/or designee weekly times four, then monthly times two with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation.

Responsible party - DON

Compliance Date – 8/24/2019