STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

PATRIOTS GLEN OPERATIONS
PATRIOTS GLEN
1640 148TH AVE SE
BELLEVUE, WA 98007

RE: PATRIOTS GLEN License # 2121

Dear Administrator:

This letter addresses Compliance Determination(s) 37319 (Completion Date 03/01/2024) and 33340 (Completion Date 12/18/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/01/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2381-2-b-iii, WAC 388-78A-2850-1-b-i, WAC 388-78A-3040-2-a, WAC 388-78A-3040-2-b, WAC 388-78A-2610-1, WAC 388-78A-2610-2-a, WAC 388-78A-2466-1-a, WAC 388-78A-2260-2-d

The Department staff who did the on-site verification:
Michelle Yip, ALF Licensor
Thomas Forkgen, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 2121	Compliance Determination # 33340
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection on 12/04/2023, 12/04/2023, 12/07/2023 and 12/07/2023 of:
PATRIOTS GLEN
1640 148TH AVE SE
BELLEVUE, WA 98007

The following sample was selected for review during the unannounced on-site visit: 7 of 47 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Kathy Young, Licensor
Michelle Yip, ALF Licensor
Thomas Forkgen, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Laurie Anderson — Residential Care Services
12/19/2021 — Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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Administrator (or Representative) 12/22/23 Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iii) Has areas protected from direct sunshine and rain throughout the day;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide 23 of 23 residents with an area protected from rain, in its outdoor courtyard, within the secured memory care unit. This failure placed the residents at risk of a diminished quality of life by limiting the residents' freedom of movement.

Findings included...

Observations of the memory care unit on 12/04/2023 at 11:49 AM, showed ambulatory memory care residents walked independently throughout the unit. Observations of the memory care unit courtyard on 12/04/2023 at 11:50 AM and on 12/05/23 at 12:50 PM, showed the facility provided no protected areas that would accommodate and encourage outside movement of memory care residents.

During an interview on 12/04/2023 at 11:49 AM, Staff O, Resident Life Aid, stated that the memory care unit used umbrellas that work for sun protection. Staff O stated that the facility had no coverings that worked to shield the residents from the rain.

During an interview on 12/5/2023 at 12:50 PM, Staff N, Resident Life Coordinator, stated that the outdoor courtyard had no awnings or umbrellas to keep memory care residents protected from the rain.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2121	Compliance Determination # 33340
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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/1/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 12/22/23 Date

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to get approval from Construction Review Services (CRS) prior to cutting an opening into a fire-rated wall to insert a fish tank. This failure placed the residents at risk of harm in the event of a fire.

Findings included...

Review of the facility's construction drawing showed a 59.126-inch-wide opening in the wall, between the lobby and main dining room, to accommodate a fish tank.

Observations from 12/04/2023 to 12/07/2023 between 8:00 AM and 4:00 PM, showed the facility inserted a fish tank into the fire-rated wall, between the lobby and the main dining room.

During an interview on 12/04/2023 at 12:50 PM, Staff P, Maintenance Director, stated that the fish tank inserted into the lobby/main dining room wall was one of the building projects completed during 2023. Staff P stated that they were unaware if the project was reviewed and approved by CRS.

During an interview on 12/05/2023, Staff A, Executive Director, confirmed that the fish tank was added into the wall in 2023. Staff A stated that they were unaware if the project was reviewed and approved by CRS.

During an interview on 12/11/2023 at 10:01 AM, Collateral Contact 1 (CC1), President of the Construction and Development company, stated that the project was not reviewed and approved by CRS. CC1 stated that the addition of a fish tank probably should have been addressed with a Technical Assistance meeting to determine if a formal CRS review was required.

During interviews on 12/11/2023 at 11:51 AM and 12:17 PM, Collateral Contact 2 (CC2), Residential Care Manager, Washington State Department of Health and CRS stated that the project required review and approval by CRS. CC2 stated that the facility created a risk of fire spreading quicker by altering a fire-rated wall.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/1/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date 12/22/23

WAC 388-78A-3040 Laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure memory care resident laundry was handled in an environment that separated clean and dirty laundry items. This failure placed all the memory care residents at risk of illness due to potential cross-contamination of laundry.

Findings included...

Review of the facility's undated policy titled, "Housekeeping Policies and Procedures", showed that to prevent the spread of infections and cross contamination, the staff should

always maintain separation in the laundry room between clean and soiled linen. The policy stated that soiled laundry must be placed in the designated laundry basket. The policy stated that clean laundry must not be stored on the soiled laundry side of the laundry room.

Observation of the memory care laundry room on 12/04/2023 at 12:08 PM, showed a wire shelf along the left side wall, adjacent to the washing machine. Observation showed the shelf was used for clean laundry, which was folded and placed on the shelf. Sweaters and shirts were hanging from hangers across the bottom of the shelf. Observation showed soiled bedding was piled on the floor next to an empty laundry basket and in front of the washing machine. The sleeve of one of the laundered sweaters was hanging within two inches of the soiled bedding. Observation showed the area around the entire laundry room was used to store laundered clothing and bedding without following the facility's policy related to infection control to keep soiled and clean laundry separated.

During an interview on 12/04/2023 at 12:09 PM, Staff M, Health and Wellness Director, stated that the staff did the laundry for all the memory care residents. Staff M stated that staff were trained to the policy which required separation of clean and soiled laundry for infection control.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/4/23 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 12/22/23 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement the respiratory protection program (RPP) for 3 of 10 sampled staff (Staff B, Staff Q, and Staff R) to reduce the potential spread of infectious diseases. This failure placed all residents at risk of contracting and spreading a potentially life-threatening infectious disease.

Findings included...

Review of the Washington State Department of Health (DOH) website, titled "Respiratory Protection Program for Long-Term Care Facilities", (https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/respiratory-protection-program), showed that facilities were required to identify which employees would be exposed to a respiratory hazard, to fit test those employees who could potentially be exposed to a respiratory hazard, and to maintain the employees' fit test records. Facilities were required to provide initial and annual fit tests and to provide fit tested respirators to their employees.

Review of the facility's Respiratory Protection Program (RPP) for use by Healthcare Facilities during the COVID-19 Pandemic document, dated June 2020, showed that Staff A, Executive Director, was the respiratory protection program administrator for the facility. The document showed respirators would be used to protect against transmission of SARS-COV-2 virus and other airborne diseases. The document identified the categories of employees who would be required to participate in the RPP, which included Certified Nursing Assistances (CNA), Registered Nurses (RN), Health Care Assistants/Caregivers, Maintenance staff, housekeeping staff, physical therapists, administrative staff, and others. The document showed that every employee required to wear a respiratory mask would be provided with a medical evaluation before they were allowed to use the mask. All designated staff would be fit-tested before use of the respirator mask.

Review of the facility's six sampled employees' records who were identified as required employees who received medical evaluations, respirator fit testing, and training showed three of the staff were not fit tested. The records showed that the facility hired Staff B, Resident Life Aide, on 06/30/2022; Staff C, Resident Life Aide, on 09/15/2023; and Staff D, Resident Life Aide, on 08/03/2022.

During an interview on 12/05/2023 at 10:15 AM, Staff A stated that the facility did not require medical evaluations, fit testing, and training for staff. Staff A stated that they understood "potential for exposure" meant only when COVID was active and identified in the facility. Staff A stated that they would only assign those staff who were medically evaluated, fit tested, and trained to provide services to COVID positive residents. Staff A stated that they would reassign those staff who were not fit tested to work in other areas or send them home. Staff A stated that if needed, they would come in and work as well as Staff M, LPN, Health and Wellness Director. Staff A stated that when needed, they hire agency staff to work with the COVID positive residents. Staff A stated that the facility offered routine medical evaluations, fit testing, and training for staff through an outside provider, and they notify staff ahead of time when the testing would occur. Staff A stated that many of the staff failed to show up to be fit tested. Staff A stated that they did not want to require staff to be fit tested to work due to the difficulties of hiring and retaining staff. Staff A stated that he did not want to create another barrier for employment. During the interview Staff A identified Staff M as the RPP administrator.

During an interview on 12/06/2023 at 12:30 PM, Staff M, stated that on 12/05/2023, Staff A informed Staff M that they were the RPP Administrator. Staff M stated that they had not read or looked at the RPP and needed to do so. Staff M stated that if the facility had four residents who tested positive for COVID they would consider that an outbreak and the facility would go into lockdown. Staff M stated that all staff would be required to wear N95 masks. Staff M stated that all staff were fit tested and trained.

Review of an email received from Staff A on 12/11/2023 at 4:37 PM, showed several residents tested positive for COVID. The email showed one resident presented with respiratory symptoms.

Review of a facility filed report to the Department of Social and Health Services on 12/11/2023 showed that seven residents tested positive for COVID. The report showed the facility followed the Department of Health guidelines.

During an interview on 12/12/2023 at 3:14 PM, Staff M stated that one resident tested positive for COVID the morning of 12/11/2023. Staff M stated that the resident experienced two episodes of emesis (vomit) , at which point they were tested. Staff M stated that the facility went into lock down and the COVID positive residents were isolated to their apartments. The dining room was closed, and group activities were cancelled. Staff M stated they instructed all the staff to wear masks. Staff assigned to provide care for COVID positive residents were required to wear N95 respirator masks that they were fit tested for. Staff M stated they did not know if the staff assigned to provide care for COVID positive residents were fit tested.

During an interview on 12/18/2023 at 2:03 PM, Staff N, Registered Nurse, Resident Care Coordinator, stated that there were three teams of staff, and each team was assigned a specific section of apartments to provide care. Staff N stated that if a COVID positive resident resided in a specific team's section, the staff of that team provided care the resident. Staff N was unable to state whether the staff that provided the care to the COVID positive residents were medically evaluated for a respirator, fit tested, and received RPP training, as required. Staff N stated that as of 12/18/2023, there were four staff members who tested positive for COVID. Staff N identified two staff nurses Staff Q, LPN, and Staff R, LPN, one caregiver, and one dining room server. Staff N stated that both nurses provided care to the COVID positive residents. Staff N stated that all the staff were required to wear masks and that outside of each COVID positive residents' apartment, there was Personal Protection Equipment setup for staff to use.

Review of Staff Q's facility records showed a medical clearance evaluation for respirator use, dated 02/22/2023. The medical clearance evaluation showed Staff Q was unable to use the respirator and needed to retest. Review of Staff R's facility records showed no records on-site for a medical clearance evaluation, respirator fit testing, and RPP training. Review of an email from Staff S, Business Office Manager, dated 12/18/2023, showed that the facility did not have any documentation of Staff R's respiratory evaluations, fit testing, or training. The email showed that Staff S requested the documentation from Staff R's former employer.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/1/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) Date 12/12/23

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 1 of 1 staff (Staff A, Executive Director) completed a Washington State name and date of birth background check (BGI) for every two years. This failure placed all residents at risk for abuse, neglect, or exploitation from staff with an unknown background.

Findings included...

Observation on 12/04/2023 at 9:30AM, showed Staff A had access to residents without a current BGI. Observation showed Staff A interacted with residents in the lobby area of the facility.

Review of the facility's employee roster showed the facility hired Staff A on 10/31/2021. Review of the records showed that Staff A's initial Washington state name and date of birth BGI expired on 11/10/2023. The records showed that on 12/04/2023, the facility completed a new BGI, 24 days after the initial BGI expired.

During an interview on 12/06/2023 at 3:12 PM, Staff R, Business Office Coordinator, stated that they were responsible for conducting the background checks and fingerprint checks for all employees. Staff R stated that they were aware Staff A's initial BGI expired and was due for renewal. Staff A stated that they immediately processed a new BGI when they realized Staff A's initial BGI expired.

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Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/1/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date 12/22/23

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure Memory Care unit medication room was locked and secured when left unsupervised by staff. This failure placed the 13 Memory Care residents at risk for harm or illness if the medications and chemicals were accessed and swallowed.

Findings included...

Review of the facility's Resident Characteristics Roster showed that 13 residents resided in the secured Memory Care unit of the facility. The Roster showed six residents ambulated independently and two used assistive devices for ambulation. The roster showed all the residents were diagnosed with dementia or Alzheimer's disease. There were four residents also diagnosed with mental health issues.

Observation on 12/06/2023 at 9:08 AM showed the medication room door was propped open. There were no staff observed in the vicinity of the medication room. Observation showed a white cabinet sat next to the entry door. The cabinet had four doors that were all unlocked. The cabinet held "extra" medications. There was a clear plastic bag which contained prescription and nonprescription medications. In the bottom of cabinet, there were several chemical, cleaning spray bottles. Inside the medication room was a white countertop refrigerator that was unlocked. The refrigerator contained suppositories (rectal medications) and other refrigerable items.

Observation on 12/06/2023 at 11:50 AM, showed the medication room door unlocked and

propped open. There were no staff in the vicinity of the medication room. The medication room was found to be unsecured and unsupervised.

Observation on 12/06/2023 at 11:50 AM, showed two residents wandered independently in the hallway next to and by the unsecured medication room. There were no staff in the vicinity of the medication room.

Observation on 12/07/2023 at 10:25 AM showed the door to the medication room was unlocked and propped wide open. The cabinet doors remained unlocked, which left the prescription and nonprescription medications accessible. The white countertop refrigerator remained unlocked.

Observation on 12/07/2023 at 10:25 AM showed a single resident ambulated back and forth in the hallway next to the unsecured medication room. The resident mumbled nonsensically as they wandered back and forth.

During an interview on 12/07/2023 at 10:38 AM, Staff N, Registered Nurse, Staff Coordinator, stated that the door to the medication room should be secured before any staff leave the area unsupervised.

During an interview on 12/07/2023 at 1:30PM, Staff A, Executive Director, acknowledged that the unlocked medication room should always be locked and secured when staff were not present.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PATRIOTS GLEN is or will be in compliance with this law and / or regulation on (Date) 2/1/24.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date 1/3/24

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

12/19/2023

PATRIOTS GLEN OPERATIONS
PATRIOTS GLEN
1640 148TH AVE SE
BELLEVUE, WA 98007

RE: PATRIOTS GLEN # 2121

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 12/18/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:
- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Laurie Anderson, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Avenue S, Suite 400

Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

The facility failed to ensure the Medicaid policy notice was written and printed in the font sized at least fourteen points. The facility corrected by updating the font size of the Medicaid policy notice during the licensing inspection.

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

The facility failed to have locked storage in the assisted living apartments. The facility corrected the failure at the time of the inspection by adding locked storage to each assisted living apartment.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.

o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure

PATRIOTS Glen
ASSISTED LIVING & MEMORY CARE
A CAREAGE COMMUNITY

Plan of Correction for 2023 Survey

Re: *WAC 388-78A-2381*: Correction-All Weather Umbrella purchased for placement outside in the Memory Care courtyard. Monitoring-Area to be inspected with regularly scheduled facility walkthroughs.

Re: *WAC 388-78A-2850*: Correction- F/U with the construction management company and CRS to ensure review is complete. Monitoring- Do not allow future projects managers to perform own review independently and follow up directly with CRS on future projects.

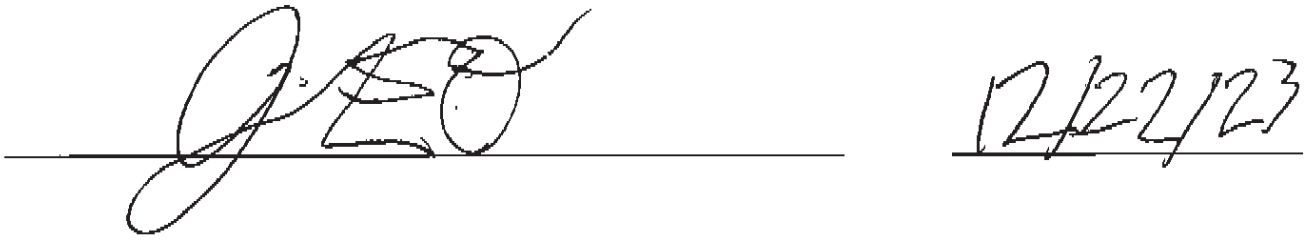
Re: *WAC 388-78A-3040*: Correction- Memory care laundry room reorganized to provide clear dirty and clean sides. Shelving removed from dirty side so as to not encourage use with clean clothes. Permanent signage to be posted to clearly label each side of laundry room. Monitoring- Area to be inspected with regularly scheduled facility walkthroughs.

Re: *WAC 388-78A-2466*: Correction- All background checks brought up to date. Monitoring- Direct managers will contact staff each month to F/U on completing background checks. HR managers will F/U with Managers directly for incomplete background checks and with managers with their own background checks.

Re: *WAC 388-78A-2260*: Correction- Door closed on nursing office when nurse and/or other staff not present. Permanent signage to be placed in office and on door to remind staff to keep door closed when not present in office. All staff will be reminded that door should be closed when staff not present and to correct/report when observed. Monitoring- If door is

observed open when any managing staff is walking through the unit spot correction will be made and noted in employee's file.

Re: *WAC 388-78A-2610*: Correction- Patriots Glen RPP updated to add clarification to practice and implementation. Adjunct policy created to clarify what staff who haven't been fit tested yet or who are medically unable to wear masks are assigned. HWD in progress of taking over regular fit-testing from Northwest. Monitoring- ED and HWD will help ensure enforcement and maintenance of RPP both in and out of outbreak status.



Jordan Drew, LPN, ED

12/22/23

Date