STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A005	A. BUILDING: _____ B. WING _____	C 10/30/2025

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PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

(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
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00189083, NJ00188898, NJ00188592, NJ00169963 CENSUS: 95 SAMPLE SIZE: 8 SURVEY DATE: 10/28/2025 - 10/30/2025 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect;	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/15/25

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A 389	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure residents did not [NJ Exec Orde] from the facility without staff's knowledge for 1 (Resident #1) of 5 sampled residents reviewed for resident safety. Specifically, on [NJ Exec Order 26.4b1] at 11:00 AM Resident #1 [NJ Exec Order 2] from the facility and was [NJ Exec Order 26.4b1] at 11:25 AM. It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairment, or death to residents. On 10/29/2025, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director and Director of Wellness were verbally informed of the immediacy of the situation involving the resident's [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1] Findings included: An undated facility policy titled, "Missing Resident," revealed "Policy: It is the policy of [name of the facility] to follow specific guidelines when a resident is missing. Procedure: 1. The Nurse on the unit is to be made ware. DON [Director of Nursing] will notify the ED [Executive Director]. 2. All staff in that unit immediately look for the resident. ALL CLOSETS, BATHROOMS, SHOWERS, UNDER THE BED AND THE ENTIRE ROOM ARE TO BE SEARCHED. 3. Once all rooms have been deemed clear on that unit. CODE GREY is to be called over the radio. 4. All other floors are to be searched. ALL	A 389		

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A 389	Continued From page 2 CLOSETS, BATHROOMS, SHOWERS, UNDER THE BED AND THE ENTIRE ROOM ARE TO BE SEARCHED. 5. Available staff are to search outside of the building. 6. After a COMPLETE search of all rooms and grounds has been completed, you are calling 911 to report that the resident has eloped. Then call the family to notify them of the situation. This should not be done until the search is completed, no longer than 15 minutes." The section titled, "Things to have ready for the police," included, "- Picture - Last time seen - Description of clothing that resident was wearing - Face sheet." The section titled, "Once resident is found," included, "- Notify Family and DON if not in house at the time. - A complete skin check HAS to be done." An "Admission Record" revealed the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included NJ Exec Order 26.4b1 [redacted] Resident #1's "Service Plan Report," included a focus area initiated on NJ Exec Order 26.4b1, that indicated the resident was at risk for NJ Exec Order 26.4b1 due to being NJ Exec Order 26.4b1 [redacted]. The focus area revealed that the resident NJ Exec Order 2 on NJ Exec Order 26.4b1. Interventions directed staff to send the resident to 'NJ Exec Order for an evaluation (initiated NJ Exec Order 26.4b1; in-house NJ Exec Order 26.4b1 services to follow the resident (initiated NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 ordered (initiated NJ Exec Order 26.4b1); NJ Exec Order 26.4b1 for one week NJ Exec Order 26.4b1 to the facility (initiated on NJ Exec Order 26.4b1 care staff to notify the nurse of any NJ Exec Order 26.4b1 (revision NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1 [redacted]	A 389		

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in the courtyard (initiated NJ Exec Order 26.4b1.

Resident #1's "NJ Exec Order 26.4b1 Risk Assessment," dated NJ Exec Order 26.4b1, (completed in the hospital) revealed a score of NJ E which indicated the resident had a NJ Exec Order 26.4b1.

Resident #1's behavior "Progress Notes," dated NJ Exec Order 26.4b1 at 1:24 PM, revealed a nurse was notified by a NJ Exec Order 26.4b1) that Resident #1 was NJ Exec Order 26.4b1. The notes revealed Resident #1 was NJ Exec Order 26.4b1 to their room and was resting on the sofa. The notes revealed that all staff were advised to pay additional attention to Resident #1 for NJ Ex Order 26.4(b)(1) purposes. The notes revealed the Director of Wellness was notified, and the incident was documented in the 24-hour book for the oncoming shift.

Resident #1's NJ Exec Order 26.4b1 "Progress Notes," dated NJ Exec Order 26.4b1 at 5:44 PM, revealed a nurse was notified by an NJ Exec Or that Resident #1 was NJ Exec Order 26 and NJ Exec Order 26.4b1, stating, NJ Exec Order 26.4b1." The notes revealed the nurse, and another nurse went outside, and spoke with the resident, NJ Exec Order 26.4b1. The notes revealed Resident #1 was NJ Exec Order 26.4b1 and came to the NJ Exec Order 26.4b1 for NJ Ex Order 26.4(b)(1) and watched television. The notes revealed that the DON and oncoming shift were notified.

During an interview on 10/30/2025 at 12:01 PM, Licensed Practical Nurse (LPN) #18 revealed that on NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1 where residents NJ Exec Order 26.4 on NJ Exec LPN #18 stated that staff followed Resident #1 NJ Exec Order 26.4b1, and Resident #1 was NJ Exec Order 26.4b1 into the facility. LPN

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#18 stated that Resident #1 was NJ Exec Orde and NJ Exec Order 26.4b1. LPN #18 stated that Resident #1 was placed in the NJ Exec Order 26.4b1 so that staff could keep a NJ Exec Order 26.4b1 on Resident #1. LPN #18 further stated that at that time Resident #1 was not admitted to the NJ Exec Order 26.4b1; they were just placed there for NJ Exec Order 26.4b1. LPN #18 said the Director of Wellness and doctor were notified. LPN #18 stated that Resident #1 NJ Exec Order 26.4b1, their NJ Exec Order 26.4b1, and they NJ Exec Order 2 a NJ Exec Order 26.4b1.

Resident #1's NJ Exec Order 26.4b1 "Progress Notes," dated NJ Exec Order 26.4b1 at 5:32 AM, revealed Resident #1 NJ Exec Order 26.4b1. The notes revealed the resident was NJ Exec Order 26.4b1 in the hallway with NJ Exec Order 26.4b1 asking staff, "NJ Exec Order 26.4b1" The notes revealed that as-needed medication was administered and was NJ Exec Order 26.4b1 at that time. The notes revealed the resident NJ Exec Order 26.4b1 assistance from staff and preferred to NJ Exec Order 26 their NJ Exec Order 26.4b1 their own.

Resident #1's nursing "Progress Notes," dated NJ Exec Order 26.4b1 at 12:17 PM, revealed a late entry that indicated the Director of Wellness was made aware by a nurse on the NJ Exec Order 26.4b1 that Resident #1 had NJ Exec Order 26.4b1. The notes revealed that a NJ Exec Order 26.4b1. The notes revealed that all staff assisted in NJ Exec Order 26.4b1 Resident #1. Per the notes, staff NJ Exec Order 26 Resident #1 NJ Exec Order 26.4b1. The notes revealed Resident #1 NJ Exec Order 26.4b1 with staff and NJ Exec Order 26.4b1. The notes revealed Resident #1 was NJ Exec Order 26.4 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.

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Per the notes, "NJ Exec Order 26.4b1) took Resident #1 to a hospital for an evaluation. The notes revealed Resident #1 NJ Exec Order 26.4b1 when the housekeeper was entering.

Resident #1's NJ Exec Order 26.4b1 "Progress Notes," dated NJ Exec Order 26.4b1 at 12:53 PM, revealed that at approximately 11:00 AM, staff was entering the NJ Exec Order 26.4b1 when Resident #1 was on the NJ Exec Order 26.4b1. The notes revealed a nurse NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1 The notes revealed staff did not make sure that the NJ Exec Order 26.4b1 behind them when Resident #1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The notes revealed emergency medical transport and NJ Exec Order were called. Per the notes, Resident #1 was NJ Exec Order 26 by staff and was NJ Exec Order 26.4b1 to the facility. The notes revealed Resident #1 NJ Exec Order 26.4 to NJ Exec Order 26.4b1. The notes revealed Resident #1 was then transported by emergency medical transport to a hospital. Per the notes, the resident's Medical Doctor (MD) was aware, and a phone call was placed to Resident #1's NJ Exec Order 26.4 and a message was left on voicemail to return the call.

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 at 11:00 AM, revealed a housekeeper was entering the unit, and Resident #1 was NJ Exec Order 26.4b1. The report revealed the housekeeper was NJ Exec Order 26.4b1 Resident #1 from NJ Exec Order 26.4b1. The report revealed the housekeeper then notified a nurse, who immediately NJ Exec Order 26.4b1 Per the report, a NJ Exec Order 26.4b1. The report revealed that all available staff NJ Exec Order 26.4b1 and NJ Exec Order 26 The report NJ Exec Order 26.4b1 were called at 11:20 AM and Resident #1 was NJ Exec Order 26.4b1 at

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A 389	Continued From page 6 11:25 AM. The report revealed staff were able to get the resident NJ Exec Order 26.4b1 . The report revealed Resident #1 was NJ Exec Order 26.4b1 to the building. The report revealed the NJ Exec Order arrived at 11:30 AM and were notified that the resident was NJ Exec Order 26.4 The report revealed Resident #1 stated NJ Exec Order 26.4b1 . The report revealed Resident #1 was evaluated for NJ Exec Order 26.4 and NJ Exec Order 26.4b1 . The report revealed Resident #1 remained NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . Per the report, an NJ Exec Order 26.4b1 arrived, and Resident #1 was taken to " NJ Exec Order at the hospital for an evaluation. The report revealed Resident #1 was admitted to the facility on NJ Exec Order 26.4b1 and had diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . The report revealed the resident was placed on the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Resident #1's nursing "Progress Notes," dated NJ Exec Order 26.4b1 at 6:59 PM, revealed Resident #1 was NJ Exec Order 26.4b1 transport and NJ Exec Order 26.4b1 . The notes revealed Resident #1 was still NJ Exec Order 26.4b1 . The notes revealed Resident #1 stated, "NJ Exec Order 26.4b1 ." The notes revealed Resident #1 was in their room and was on NJ Exec Order 26.4b1 . During an interview on 10/28/2025 at 10:21 AM, the Assistant Director of Nursing (ADON) revealed that she was working on the day of the incident, and she was on break when the incident occurred. During an interview on 10/28/2025 at 10:45 AM, Certified NJ Exec Order 26.4b1) #1 revealed that she had worked with Resident #1 before they were transferred to the NJ Exec Order 26.4b1 , and	A 389		

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Resident #1 would NJ Exec Order 26.4b1 . NJ Exec Order 2 #1 indicated that she was not working during the day of the incident.

During an interview on 10/29/2025 at 4:35 PM, Registered Nurse (RN) #17 revealed that Resident #1 had NJ Exec Order 26.4b1. RN #17 stated that Resident #1 NJ Exec Order 26.4b1 RN #17 stated the staff would NJ Exec Order 26. Resident #1 by NJ Exec Order 26.4b1 . RN #17 stated that staff were NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26. RN #17 said that Resident #1 NJ Exec Order 26.4b1 . RN #17 stated that she did not witness the incident.

During an interview on 10/28/2025 at 11:09 AM, Housekeeper #2 revealed that he was going into the NJ Exec Order 26.4b1 unit, and Resident #1 NJ Exec Order 26.4b1 . Housekeeper #2 said Resident #1 was NJ Exec Order 2 Housekeeper #2 said he left Resident #1 near the stairwell to get the nurse. Housekeeper #2 said that when NJ Exec Order 26.4b1 Resident #1 had NJ Exec Order 26.4b1

An observation was made on 10/29/2025 at 3:49 PM with the Maintenance Director of the area that Resident #1 could have NJ Exec Order 26. The area from the secured unit door to the front door was 158 steps (including 14 steps up on the stairway). The second possible area was 65 steps (including eight steps down) leading to the service area, and the door led to the dumpster area, and the state highway was about 300 yards from the door.

An observation was made on 10/29/2025 at 11:55 AM of the front door with a green button to the right of the door to exit out of the facility. The receptionist must unlock the front door for entry

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A 389	Continued From page 8 into the facility. During an interview on 10/29/2025 at 12:00 PM, the Receptionist Security Supervisor revealed that all independent living and assisted living facility residents were allowed to go outside on the porch without staff or family. The Receptionist Security Supervisor stated that the smoking area was right outside to the left. The Receptionist Security Supervisor stated that she was not working during the time of the incident. The Receptionist Security Supervisor stated she was aware of the elopement risk book with pictures of residents at the receptionist counter. During an interview on 10/29/2025 at 4:28 PM, Receptionist #16 revealed that the front desk was busy at times and unfortunately, she did not see Resident #1 NJ Exec Order 26.4b1 of the incident. Receptionist #16 stated that there was an NJ Exec Order 26.4b1 resident risk notebook with NJ Exec Order 26.4 of residents at risk for NJ Exec Order 26.4b1 kept at the desk. Receptionist #16 stated that NJ Exec Order 26.4b1 was called, and staff started NJ Exec Order 26.4b1 for Resident #1 During an interview on 10/28/2025 at 11:00 AM, LPN #3 revealed that Housekeeper #2 told her Resident #1 got out of the NJ Exec Order 26.4b1. LPN #3 stated that she notified the Director of Wellness, and a NJ Exec Order 26.4b1 was called. LPN #3 stated that staff immediately started NJ Exec Order 26 for Resident #1. LPN #3 stated that she was NJ Exec Order 26.4b1 . An "Inservice" dated NJ Exec Order 26.4b1 revealed staff were educated on "Subject: NJ Exec Order 26.4b1 including "If you witness a resident leaving a locked unit, you are to stay with the resident at all times. An "Employee Counseling Record" dated	A 389		

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A 389	Continued From page 9 NJ Exec Order 26.4b1 revealed Houskeeper #2 was counseled regarding the resident exiting the NJ Exec Order 26.4b1. Resident #1's "NJ Exec Order 26.4b1 for the timeframe from NJ Exec Order 26.4b1 revealed that facility staff completed NJ Exec Order 26.4b1 on Resident #1. Resident #1's "NJ Exec Order 26.4b1 Evaluation" dated NJ Exec Order 26.4b1, revealed nursing reported that Resident #1 NJ Exec Order 26.4b1 the day before and was sent to the hospital for an evaluation after NJ Exec Order 26.4b1. The evaluation revealed that the resident returned to the facility with no new orders per staff. The evaluation revealed nursing staff reported that the resident had been NJ Exec Order 26.4b1 since admission and had been NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and had NJ Exec Order 26.4b1. The evaluation revealed Resident #1 was seen by primary care provider (PCP) earlier that day and was prescribed NJ Exec Order 26.4b1 (PO) every night at bedtime (QHS) for NJ Exec Order 26.4b1 per the nursing staff. The evaluation revealed that on assessment, the resident was observed NJ Exec Order 26.4b1 and did not NJ Exec Order 26.4b1 The evaluation revealed Resident #1 NJ Exec Order 26.4b1 during the assessment. The evaluation revealed that clinical signs and NJ Exec Order 26.4b1 included NJ Exec Order 26.4b1. The evaluation revealed that the "Assessment/Plan" included to always consider supportive and individualized non-pharmacologic interventions, including, NJ Exec Order 26.4b1;	A 389		

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treat medical issues including NJ Exec Order 26.4b1 [redacted]; encourage participation in activities, NJ Exec Order 26.4b1 as NJ Exec Order 26.4b1 and as possible for NJ Exec Order 26.4b1 wellbeing. The Assessment Plan revealed a recommendation to increase NJ Exec Order 26.4b1 PO every 12 hours; to continue all other medication regimens; to observe any changes in NJ Exec Order [redacted]; and to document any changes.

During an interview on 10/28/2025 at 2:44 PM, the Certified Dietary Manager (CDM) revealed that he NJ Exec Order 26.4b1 for Resident #1 NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec O Resident #1 NJ Exec Order 2 The CDM said the NJ Exec Order 26.4b1 was on the NJ Exec Order 26.4b1. The CDM indicated that Resident #1 was NJ Exec Order 26.4b1 [redacted]. The CDM said it was not cold or raining outside during the time of the incident.

An NJ Ex Order 26.4(b)(1) service revealed that the NJ Exec Order 26.4b1 where Resident #1 was found after they NJ Exec Order 2 was approximately NJ Exec Order 26.4b1 [redacted]

An observation was made on 10/28/2025 at 8:45 AM of the NJ Exec Order 26.4b1; it was noted to be a NJ Exec Order 26.4b1.

A review of the past weather in the Township of Cherry Hill located on timeanddate.com revealed the weather on NJ Exec Order 26.4b1 around 11:00 AM was 64 degrees Fahrenheit with scattered clouds.

During an interview on 10/28/2025 at 3:08 PM, the Director of Wellness revealed that the

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housekeeper was disciplined and provided training. The Director of Wellness revealed that it was her expectation that a resident did not [NJ Exec redacted] by staff or family. The Director of Wellness stated that it was her expectation that staff remained with the resident while the resident was [NJ Exec Order 26.4b1 redacted]. The Director of Wellness stated that Resident #1 [NJ Exec Order 26.4b1 redacted] and was moved to the [NJ Exec Order 26.4b1 redacted] on [NJ Exec Order 26.4b1 redacted], and Resident #1's [NJ Exec Order 26.4b1 redacted] was placed in the [NJ Exec Order 26.4b1 redacted] Risk Notebook on [NJ Exec Order 26.4b1 redacted].

During an interview on 10/28/2025 at 3:10 PM, the Executive Director revealed that it was her expectation that a resident did not [NJ Exec Order 26.4b1 redacted] by staff or family. The Executive Director stated that it was her expectation that staff remained with the resident while the resident was [NJ Exec Order 26.4b1 redacted].

During an interview on 10/29/2025 at 3:30 PM, the ADON revealed that there were no additional interventions for Resident #1 when they were [NJ Exec redacted] other than to [NJ Exec Order 26 redacted] the resident and keep a [NJ Exec Order 26.4b1 redacted] on the resident.

During an interview on 10/30/2025 at 4:20 PM, the MD revealed that he saw Resident #1 on [NJ Exec Order 26.4b1 redacted] after the incident, and Resident #1 [NJ Exec Order 26.4b1 redacted] the facility. The MD stated that when residents first came to the facility, [NJ Exec Order 26.4b1 redacted]. The MD stated that he saw Resident #1 that day, and Resident #1 was [NJ Exec Order 26.4b1 redacted].

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15A005 Y1	A. Building B. Wing Y2	12/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 11/26/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/30/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: UY4312

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
15A005 Y1	A. Building B. Wing Y2	12/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/30/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: UY4312