New Jersey Department of Health

		IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
	D35019		B. WING			C <b>04/17/2024</b>		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FOX TRA	FOX TRAIL MEMORY CARE LIVING PARK RID( 103 KINDERKAMACK ROAD PARK RIDGE, NJ 07656							
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE			
R 000	Initial Comments			R 000				
	Type of survey: Co	omplaint						
	Complaint #: NJ00	172134						
	Census: 8							
	Sample: 3							
		compliance with all o J.A.C. 8:37 Standard ntia Care Homes.						
R 016	8:37-1.1(b) Purpose	e and Scope		R 016				
	This chapter is promulgated for the purpose of establishing interim licensing standards for dementia care homes in the State of New Jersey to ensure that they are maintained and operated in such a manner that will protect the health, safety and welfare of its residents and at the same time preserve and promote a home-like atmosphere appropriate to such facilities.							
	This STANDARD is Complaint #: NJ00	s not met as evidence 172134	ed by:					
	determined that the policy and procedur by not reporting pot 1 of 3 residents. Re	and record review, it facility failed to follow re titled, "Incident Rep tential incident to all p esident #2. This defici need by the following:	wits porting" parties for ent					
	the closed medical	p.m., the surveyor re- record (MR) of Resid o the facility for western	lent #2					

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

TITLE (X6) DATE

THE WOOL	sey Department of I	icaili i				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
					_ ا	
		Boso40	B. WING		C	
		D35019	5. 11.110		<u>  U4/1</u>	7/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		103 KIND	ERKAMACK	ROAD		
FOX TRA	AIL MEMORY CARE L	IVING PARK RID(	GE, NJ 076			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
		•		DEFICIENCY)		
D 040	0 " 15		D 040			
R 016	Continued From pa	ige 1	R 016			
	NJ Ex Order 26.4(b)(1) from NJ Ex	order 26.4(b)(1) to NJ Ex Order 26 With				
	diagnoses of NJ Ex					
	NJ Ex Order 26.4(b					
	110 EX 01401 20.1(b	<i>/</i> .				
	On 3/19/24 at 2:13	p.m., the surveyor interviewed				
		ector (CD) regarding Resident				
		stated the resident liked to				
		6.4(b)(1). The CD stated that on				
	NJ EX Order 26 the resident	was NJ Ex Order 25.4(b) and pulled a				
	chair and NJ Ex Or					
	NJ Ex Order 26 4(b	. The CD explained she				
	NU Ex Order 26.4(b)(1) the reside	ent NJ Ex Order 28.4(b)(1) and assisted				
		Order 26.4(b)(1) and NJ EX Order 26				
		e resident from NJEx order 25.				
	to prevent the	resident nom				
	During the interview	v, the CD stated she did not				
		nt report or notify the resident's				
		POA) until Wexorder 25% when the				
		ons (DOO) instructed her to do				
		that she did not consider the				
		pecause there was Neconsider the				
	above as incident b					
	at the time	of the incident.				
	During continued in	stancing the CD added that				
	ofter Resident #2 w	nterview, the CD added that vas discharged on westers, she				
		n the DOO who stated the				
		ed and stated that the resident				
		6.4(b)(1) . The CD then				
	explained that she	informed the DOO she was				
	not aware of any	on discharge and				
		of the Next order 25 incident when the				
	resident NJ Ex Ord	er 20.4(b)(1)				
	A	um cas care implace sizes and the a DOO				
		urveyor interviewed the DOO				
		that she notified the CD and				
	intormed the CD to	complete an incident report				
	on NJEX Order 26.4					
		wed the facility policy and				
	procedure titled "In	cident Reporting " which	1		l l	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	D25040		B. WING			C 04/47/2024	
		D35019		D. WING	_	04/	17/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FOX TRA	AIL MEMORY CARE L	IVING PARK RIDO		ERKAMACK )GE, NJ 076			
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ACTION SHOULD BE COMPLÉT TO THE APPROPRIATE DATE		
R 016	Continued From pa	ge 2		R 016			
	anytime a matter re emergency, or unus Notifications mus	ent Report will be initi- elated to safety, medi- sual occurrence take t be made to RDON J, MD [Medical Docto ) at time of incident	cal s place. [Regional				
	Reference: 8:37-7.9	9(1)(h)					
R 872	8:37-5.9(b) Persona	al Care-Laundry Ser\	/ices	R 872			
	Each resident's laudidentified to prevent	ndry shall be properly t loss.	y				
	This STANDARD is Complaint #: NJ00	s not met as evidenc 172134	ed by:				
	determined that the personal laundry wa	and record review, it facility failed to ensu as labeled to prevent r 1 of 3 residents. Re following:	ure from loss				
	the closed medical who was admitted to on was admitted to the "Resident Pe	rsonal Property Inve was admitted with tw	dent #2 care According ntory				
	Community Directo personal clothing a	rveyor interviewed the r (CD) regarding Resond belongings. The Control and work and work the resonance research to the r	sident #2's CD stated				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		D35019	B. WING		C 04/17/2024	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FOX TRA	AIL MEMORY CARE L	IVING PARK RID(	DERKAMACK DGE, NJ 076			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
R 872	Continued From pa	age 3	R 872			$\neg$
	the clothes up with Additionally, the CE resident was discha clothing was missin facility did not label The facility failed to	other residents belongings. D explained on the date the arged process, some of the ng. Further, the CD stated the personal belongings.				
	#2 S CIOTINS UPON GIS	scharge from the facility on				
R1000	8:37-6.2(a)(1) Phar Medication	rmacy-Administration of	R1000			
	Facilities employing certified medication aides to administer medications to residents shall comply with the requirements at N.J.A.C. 8:36-11.5.					
	This STANDARD is Complaint#: NJ00	is not met as evidenced by: 172134				
	review, and review it was determined the administer medicate resident's physician 8:36-11.5(f) for 1 of	y, observation, medical record of pertinent facility documents, that the facility failed to tion as ordered by the n in accordance with N.J.A.C. f 3 residents, Resident #2. This yas evidenced by the following:	3			
	shall be accurately	C. "8:36-11.5(f) Medications administered and documented zed individuals, in accordance lers."				
	interviewed the Cer regarding medication	0 a.m., the surveyor rtified Medication Aide (CMA) on administration and cedures. The CMA stated that				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	D35019		B. WING		C 04/17/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	•	
THAME OF I	NOVIDER OR SOLVEIER		ERKAMACK			
FOX TRA	AIL MEMORY CARE L	IVING PARK RID(	GE, NJ 076			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
R1000	Continued From pa	ige 4	R1000			
	the facility used an Administration Recomedication. Addition after a medication with sign out the medical also stated that if a the eMAR had a driverason why a medical On 3/19/24 at 1:40 the closed medical During the MR reviewed a total of	electronic Medication ord (eMAR) to administer nally, the CMA explained that was administered she would ation in the eMAR. The CMA resident refused a medication op down box to note the cation was not administered.  p.m., the surveyor reviewed record (MR) of Resident #2.  ew, the surveyor observed the er medication administration of the cation administration of the cation administration of the cation was not administration of the cation administration of the cation administration of the cations were not reder on the following dates:				
	On NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) tablet at 9:00 p.m., for NJ Ex Order 26.4(b)(1) was not signed out as administered.					
	On NJ Ex Order 26.4(b)(1) was not signed out as administered.					
	On NJ Ex Order 26.4(b)(1) NJ Ex Order 20.4(b)(1) P.m., for NJ Ex Order 26.4(b)(1) administered.	tablet give 1 tablet at 9:00 was not signed out as				
	NJ Ex Order 26.4(b)(1) ta	blet at 9:00 p.m., for t signed out as administered.				
	NJ Ex Order 26.4(b)(1)	tablet at 8:00 a.m. for out signed out as administered.				

PRINTED: 04/04/2025 FORM APPROVED New Jersey Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING D35019 04/17/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 KINDERKAMACK ROAD FOX TRAIL MEMORY CARE LIVING PARK RID( PARK RIDGE, NJ 07656 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R1000 Continued From page 5 R1000 On NJ Ex Order 26.4(b)(1) tablet give 1 tablet at 9:00 a.m., for NJEX Order 28.4(b) was not signed out as administered. At 2:10 p.m., the surveyor interviewed the CMA regarding missing initials/signatures on the residents MAR. The CMA stated the EMAR system was not working during the residents stay to Nexoder25 and a paper MAR was used to administer medications. Additionally, the CMA explained NJ Exec Order 26.4b1 Regional Clinical Director (RCD) regarding the missed initials/signatures on the resident's MAR. The RCD stated that she went on vacation and was not aware of the missed signatures in the MAR. The surveyor then requested a removal plan from the Director of Operations (DOO) and the RCD for medications not signed out as administered for 4 days: NJEX Order 26.4(b)(1) by the CMA. At 3:30 p.m., the surveyor reviewed the facility policy and procedure titled, "Medication

STATE FORM 6899 M09F11 If continuation sheet 6 of 8

Availability/Cycle Fill" which revealed, "It is expected that medications are ...administered

On 4/11/24 at 2:55 p.m., the surveyor received a removal plan from the facility via email that was

On 4/17/24 the surveyor conducted a re-visit at

the facility and the removal plan was implemented. The surveyor observed a

and documented as ordered."

acceptable.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ \ \ \ \	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	<del></del>	С	
		D35019	B. WING		_	, 7/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FOX TRA	AIL MEMORY CARE L	IVING PARK RID(	ERKAMACK DGE, NJ 076			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
R1000	Continued From pa	ge 6	R1000			
	medication pass, interviewed staff on medication administration procedures, and reviewed staff training/in-service records.					
R1648	8:37-7.9(h) Physica	l Plant-Control of Access	R1648			
	be kept locked at al use, except when a the licensee is stati					
	This STANDARD is Complaint #: NJ00	s not met as evidenced by: 172134				
	review, it was deter secure the kitchen the kitchen when ur	, observation, and record mined that the facility failed to area from residents entering n-supervised by staff for 1 of 3 #1. This deficient practice he following:				
	community with the surveyor observed area that led into the area. Additionally, the kitchen did not have was no controlled to observed the stove to the residents who at 1:40 p.m., the sumedical record (MR)	a.m., during tour of the Community Director (CD), the that the kitchen was an open e common dining and activity he surveyor observed the e supervised entry and there ocked entry way. The surveyor foven were easily accessible or resided at the facility.  Inveyor reviewed the closed (R) of Resident #2 who was lity on				

	sey Department of F					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	<del></del>		
		D35019	B. WING		04/1	; 7/2024
NAME OF	PROVIDER OR SUPPLIER	STDEET AL	DDESS CITY S	STATE, ZIP CODE		
NAME OF	-ROVIDER OR SUFFLIER		ERKAMACK			
FOX TRA	AIL MEMORY CARE L	IVING PARK RID(	DGE, NJ 076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
R1648	Continued From pa	age 7	R1648			
	NJ Ex Order 26.4(b)(1) Plan (SP)" dated Number of the Numb	with a we code on we code and x Order 26.4(b)(1) .				
	regarding the The CD stated she	urveyor interviewed the CD  per26.4(b)(1) not being secured. was not aware that the be be secured to prevent ng into the				
	Director of Operation unsupervised NUEXOT she was not aware a barrier when unsurequested a remove barrier or controlled	urveyor interviewed the ons (DOO) regarding the the one (DOO) regarding the operation of th				
	on 4/17/24 the survive facility and the implemented. The entrance when unslock entryway. Additional control of the control of	veyor received a removal plan email which was acceptable. veyor conducted a re-visit at removal plan was surveyor observed the surveyor observed the itionally, the surveyor dereviewed training records				
		staff were aware of the new				



4/23/24

## NJ Exec Order 26.4b<sup>2</sup>

Administrator

Fox Trail Memory Care Living Park Ridge 103 Kinderkamack Road Park Ridge, NJ 07656

## R 016 8:37-1.1(b) Purpose and Scope

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #2 who was affected was discharged on
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  - All residents have the potential to be affected by this deficient practice.
  - All incident reports are reviewed by the Community Director to ensure all reporting requirements are completed weekly.
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
  - A barrier was installed on 3/20/24.
  - All staff were in-serviced on the barrier and when the bairier was put in place on 4/10/24.
  - Community Director and team members are trained on proper incident reporting procedures on 4/18/24.
  - All incident reports are reviewed by the Community Director/Designee to ensure all reporting requirements are completed.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Auditing of barrier security will be completed by the Community Director 5 x a week x 4 weeks and then 1 x month.
- All team members will be trained on incident/accident reporting upon hire and annually by Community Director/Designee.
- Completion date of 4/18/24.

R 872 8:37-5.9(b) Personal Care-Laundry Services

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #2 who was affected was discharged on
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  - All residents have the potential to be affected by this deficient practice.
  - All residents have had a standard assessment completed per regulations, that indicates
    if the community completes laundry services.
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
  - In-service completed with all staff on laundry services/clothing labeling and infection control on 4/18/24.
  - A set laundry schedule was implemented, and all team nembers were trained on schedule on 4/18/24.
  - All residents' clothing is labeled with their names upon admission and as needed.
  - All team members are trained on laundry services upon hire and as needed.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
  - Community Director/Designee is monitoring the staff assignment sheets that are signed off that the laundry is being completed.
  - Community Director/Designee is monitoring the laundry to ensure that the proper procedure is being followed 5 x's a week x 4 weeks, 1 x a week x 4 weeks, then 1 x month.

Completion date of 4/18/24.

R1000 8:37-6.2(a)(1) Pharmacy-Administration of Medication

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Resident #2 affected was discharged on
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  - All residents have the potential to be affected by this delicient practice.
  - All residents medications were reviewed to ensure that the residents are receiving their medication according to the physician orders.
- What measures will be put into place or systemic changes inade to ensure that the deficient practice will not recur.
  - In-service completed with the CMA's on 4/18/24 by RN on procedure for when medication is not administered, medication administration process, and delegation of medication administration.
  - Community Director is reviewing missed medication report daily and following up on any missed medications immediately.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
  - Community Director/Designee will audit all new admissions/new orders/pending orders to ensure that they are approved 5 x week.

Completed on 4/18/24.

R1648 8:37-7.9(h) Physical Plant-Control of Access

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #2 who was affected was discharged or
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  - All residents have the potential to be affected by this deficient practice.
  - All residents have had a standard assessment completed per regulations.
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
  - A barrier was installed on 3/20/24.
  - All staff were in-serviced on the barrier and when the barrier should be in place on 4/10.24.
  - Community Director and team members are trained on proper incident reporting procedures on 4/18/24.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
- Auditing of barrier security will be completed by the Community Director/Designee 5 x a week x 4 weeks and then 1x monthly.
- Completion date of 4/18/24.

alle pélo,4

## STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION DATE OF REVISIT PROVIDER / SUPPLIER / CLIA / **IDENTIFICATION NUMBER** A. Building 4/17/2024 B. Wing D35019 **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 103 KINDERKAMACK ROAD FOX TRAIL MEMORY CARE LIVING PARK RIDGE PARK RIDGE, NJ 07656 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 DATE ITEM DATE ITEM DATE **Y4 Y5** Y4 Y5 Y4 **Y**5 ID Prefix R0016 ID Prefix R0872 Correction ID Prefix R1000 Correction Correction 8:37-1.1(b) 8:37-5.9(b) 8:37-6.2(a)(1) Reg. # Completed Reg. # Completed Reg. # Completed LSC 07/22/2024 LSC 07/22/2024 LSC 07/22/2024 **ID Prefix ID Prefix** ID Prefix R1648 Correction Correction Correction 8:37-7.9(h) Reg. # Completed Reg. # Completed Reg. # Completed 07/22/2024 LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE REVIEWED BY **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

Page 1 of 1 EVENT ID: M09F12

YES NO

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

4/17/2024