

**STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH**

In the Matter of St. John's Lutheran
Home of Albert Lea, Survey Completed
6/30/05

**RECOMMENDED
DECISION**

This matter was the subject of an Independent Informal Dispute Resolution (IIDR) meeting conducted by Administrative Law Judge Allan W. Klein on November 29, 2005, in Minneapolis, MN. The record closed on December 12, 2005, upon delivery of an omitted exhibit.

Appearances: Marci Martinson and Mary Cahill, Division of Facility and Provider Compliance, Minnesota Department of Health, 1645 Energy Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of the Department. Susan M. Schaffer, of the firm of Orbovich & Gartner, 408 St. Peter Street, Suite 417, St. Paul, MN 55102-1187, appeared on behalf of St. John's Lutheran Home of Albert Lea. Also present were Scott Spates, Judy Dilling, Sandy Nelson, and Peggy Qual, all from the facility.

NOTICE

Under Minn. Stat. § 176.144A.10, subd. 16(d)(6), this Recommended Decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this Recommended Decision.

Based upon the exhibits submitted and the arguments made, and for the reasons set forth in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

That Citation F-223 for Resident #29 is not supported.

That Citation F-309 for Resident #25 is supported.

That Citation F-314 for Resident #14 is supported.
That Citation F-314 for Resident #16 is supported.
That Citation F-324 for Resident #20 is supported.
That Citation F-324 for Resident #23 is supported.

Dated this 9th day of April, 2011

s/Allan W. Klein
ALLAN W. KLEIN
Administrative Law Judge

Reported: Tape Recorded,
No transcript prepared

MEMORANDUM

Citation F-223

42 CFR § 483.13(b) provides that a resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The term "involuntary seclusion" does not include placement in a unit whose stated purpose is to prevent residents from free movement throughout the facility in order to provide specialized care for residents who are cognitively impaired, so long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences.

The Department cited St. John's for violating this regulation in the case of a resident who was placed in the "Sheltering Arms Memory Unit," which is a locked facility. The Department claimed there was no evidence of a pre-admission assessment to determine whether the resident was appropriate for the unit, no evidence that the family consented to the placement, and no evidence that a physician

ordered it. The facility, on the other hand, claims that the resident was appropriately admitted with symptoms of dementia, delirium and wandering. Cirrhosis with elevated blood ammonia levels was labeled most likely cause for resident's decline in cognition. Improvements were anticipated as ammonia levels decreased. On the date of his admission, June 8, his ammonia level was at 119, but by June 14, it had been brought down to 68.¹ Finally, the facility claims that the admission was initiated by the family itself, and that the family participated fully before, during and after the admission.

The facility is part of a "campus" that include an assisted living facility known as "Knutson Place," a locked unit know as "Sheltering Arms," and a traditional nursing home. Resident #29 was living at Knutson Place when the staff there noticed a change in his behavior. On June 7, 2005, he was found attempting to get into another resident's apartment, and when asked about it, said he was trying to find the pharmacy. He was very confused. Later that morning, he indicated he was trying to go to dinner, and the housekeeper redirected him. Soon after that, he was found to have placed a can of soda in his refrigerator upside down, so that the soda spilled in the refrigerator and onto the floor of his apartment. He indicated that he was waiting for his family to take him out to dinner, but a check with the family indicated that they were not planning to take him out to dinner. While a nurse was checking with the family about this, he walked past her office and outdoors. That evening, his son took him home to sleep. Family members got him ready for bed and into bed, but an hour later he was found sitting up, dressed, and ready to go out. The next morning, the family called St. John's about nursing home placement.²

On June 8, the Freeborn County Public Health Screener prepared a referral. The diagnoses listed on the referral are "dementia, malnutrition, and wandering all over at Knutson Place." In terms of ADL's, the form indicates "needs cueing and redirection" and lists an authorized admission date of June 8, 2005.³

On June 8, facility staff completed an "Information on Admission Coming From Home" form, indicating diagnoses of dementia and malnutrition. It listed his cognitive status as "confused, and mild wandering – no behaviors."⁴ The resident arrived at Sheltering Arms at 4:20 p.m. with his family.⁵ A form labeled "Admission Nursing Data" indicates that he was accompanied by "Pam-daughter-in-law," who also supplied medical information for his admission.⁶ A few hours later, at 7:00 p.m., his physician gave a new order for medication, and the progress notes "family-son and daughter-in-law and resident informed of above."

¹ Department Ex. E-20.

² Facility Exs., pp. 1-2. This, and similar references, referred to a large loose leaf book entitled "Confidential Resident Medical Information" supplied by the facility. Each page bears a Bates stamp. That stamped number is the page referred to in the footnote.

³ Facility's Exs, p. 3.

⁴ Facility's Exs. p. 4.

⁵ Department Ex. E-32a.

⁶ Facility's Exs. p. 7.

On June 9, a social service progress note indicates “resident admitted from K.P. due to confusion and safety. Family believes placement is temporary. Resident is pleasant...will monitor for concerns and appropriate placement.”⁷

On June 16, the facility completed a “Sheltering Arms Memory Unit Continued Placement Assessment” which indicates the resident does not have any form of dementia, organic brain syndrome or Alzheimer’s disease. The bottom of the form is noted “temp. placement. Trial to act. [activities] out of unit.”⁸

At the June 16 meeting, an interdisciplinary team discussed the family’s request that the resident be let out of Sheltering Arms to be on his own to wander about the facility and the outdoors. The team decided to put a security bracelet on him, and experiment with allowing him out. This was done and the resident did take advantage of this. In addition, his family took him out of the facility almost daily.⁹ On June 24, at a care plan conference, which was attended by the resident’s son, it was agreed that the long-term goal was to return the resident to his home. The son and the staff agreed that the resident was able to move out of the secure unit and that he would be put on a waiting list for a room in the regular nursing home.¹⁰

On June 17, 2005, Judy Dilling, Director of Nursing, dictated and signed an initial Resident Assessment Protocol Summary. In that summary, she noted that she had spoken with the resident, and he did not have any idea that he had been having problems with increased confusion. The summary went on to recite:

His family does not believe that res belongs in the unit, and based on his ability to find his room and no evidence of wandering since in the unit, even though he didn’t always know where he was at, following some trial outings to activities out of the unit, the team will reassess and most likely recommend that he move to another area within St. John’s. He does need assistance with ADL’s and meds – therefore continued nursing home placement seems to be the best fit for him, especially since he does have a Dx of dementia.¹¹

The survey began on June 27, and ended on June 30.

On June 28, a team meeting was held and it was agreed that the security bracelet could be removed because the resident had had several “trials” out of the unit and had successfully found his way back every time. The note indicates that the family was in agreement with this.¹²

⁷ Facility’s Exs., p. 11.

⁸ Facility’s Exs., p. 13.

⁹ Facility’s Exs., pp. 15-18.

¹⁰ Facility’s Exs., p. 18.

¹¹ *Id.*

¹² Facility’s Exs., p. 19.

On June 30, the last day of the survey, one of the surveyors had focused in on the propriety of the resident's admission to the unit and his continued presence there. She had conversations with a number of staff persons concerning these issues. One of them was with the Social Services Director, who allegedly stated that the admission was in order to protect the resident's safety because he was deemed "highly likely to elope." She allegedly told the surveyor that the room in the locked unit was the only room available at the time of admission.¹³ She allegedly told the surveyor that families are told about admissions to the locked unit, but there is nothing signed. She allegedly stated in this case, it was an emergency admission, but that the resident does not need the unit, that he is now on a room waiting list and that, in fact, a room opened on June 30, but the family was unable to look at it and no decision has been made as to whether or not he would move.

The Administrative Law Judge finds that, based on all the facts in the record, the facility did not involuntarily seclude Resident #29 by placing him in the locked unit from the period of June 8 through June 16, and then allowing him more and more freedom to leave the unit from June 16 onward. It is clear that the family was instrumental in removing him from Knutson Place and placing him at St. John's and that the family and staff were on the same track – to give him as much freedom as he wanted as soon as it appeared safe to allow him to leave the unit. The failure to have the family sign off on the process/criteria form does not make this violation rise to the level for a citation. Therefore, it is recommended that the citation be dismissed.

Citation F-309

Initially there were four examples relating to this citation. While the facility is contesting all four, the Department has dropped one of them (Resident #14) and the facility did not offer any evidence on two of them. The facility has requested only deletion of the findings related to Resident #25.

The regulation at issue, 42 CFR § 483.25 provides that each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The intent of the regulation is to assure the resident obtains optimal improvement or does not deteriorate within the limit of the resident's right to refuse treatment, within the limits of recognized pathology and the normal aging process.

Resident #25 suffered from itching related to his end-stage renal disease. This was causing peripheral arterial disease, and his doctor prescribed Trental in an attempt to deal with this problem. The resident began taking the Trental on April 28, 2005. After he seemed to be tolerating it well, the dosage was doubled on May 5, 2005. On May 9, 2005, a rash was noted on the trunk of his body. The rash was red and raised. He complained that it itched. Shortly after that complaint, his physician was contacted, and ordered that the Trental be discontinued until the rash was gone, but then restarted.

¹³ Department Ex. E-41b.

In addition, the physician ordered that the resident be given Benedryl every four hours, as needed for the rash. The resident received his first Benedryl on the evening of May 9 after complaining of the itching. His interdisciplinary progress note reflects that the Benedryl was effective in dealing with the itching and the rash gradually decreased in early May. On May 20, the rash had disappeared, the resident was not complaining about itching, so the Trental was restarted. Two days later, however, on May 22, the resident complained of itching, and requested that lotion be applied to his back. This was done. On June 7, the rash was back, so the Trental was discontinued. On that same date, Benedryl was resumed on an as needed basis. A care plan review conference was held on June 9, and the resident did not raise any concerns about itching, noting that he “has no concerns and that he gets good care here.” On June 15 the nursing notes indicated that he continued to itch his trunk and back area and that the rash was still present. Benedryl was continued on an as needed basis. On that date, a nursing note indicates that the resident’s wife mentioned concern about the Benedryl use because it makes him thirsty. However, he is dialysis dependent, and thus his liquid intakes must be restricted. She suggested that maybe the rash and itching was related to the detergents used to wash his clothing and bedding, and asked whether a special wash might be used to see if that made a difference. During the time from June 10 onward, Benedryl was given to the resident generally twice a day.¹⁴

The surveyors began their work on June 27. On June 30, at 9:05 a.m., a surveyor was in the resident’s room. The resident motioned the surveyor to come over and talk with him, and then proceeded to tell her that he is “itching and itching” all the way from his groin to his neck. He reported that he got an “itch pill” twice a day, but that it wasn’t doing much good. He said that the itching had been bothering him for about two months, and it was not going away. He said that he slept only two hours the previous night and when he complained, a nurse put vanicream on him but it only helped for a couple of hours. He stated that he had a doctor’s appointment on July 12, but that he can’t go that long. He said “I’m very uncomfortable. The itching is doing a pretty good job of driving me crazy.” And, “I scratch a lot too.” The surveyor checked the medical records and noted that he had only received one Benedryl the day before, and none so far that day. She inquired of the nurse manager, who didn’t know why a second Benedryl had not been given the day before. The surveyor also spoke with a nurse practitioner, who indicated that the Benedryl was scheduled to be given at 8:00 p.m. and 12:00 midnight so that the resident could get some relief while sleeping. As a result of her inquiry, the resident was given another Benedryl that morning. In addition, the nurse practitioner agreed to schedule vanicream applications more often. There was no specific schedule for the vanicream, nor was there any indication of a systematic documentation or monitoring of its efficacy.

There is no evidence in any of the records, nor is there any circumstantial evidence to suggest, that the resident knew he could ask for Benedryl and receive it on an “as needed” basis (PRN). Nor is there any evidence that the staff gave him Benedryl whenever he complained of itching. Although the current physician’s orders were for Benedryl on a PRN basis, neither the resident nor the staff seemed to be aware of that.

¹⁴ Department Ex. H-17a and H-17b.

The facility suggests that the surveyor has exaggerated the importance of this matter, and that between the Benedryl and the vanicream, the resident's itching was being adequately treated. Moreover, the facility points out that when the resident finally did see a dermatologist on July 12, the dermatologist concluded that the resident was allergic to Benedryl, and Benedryl was added to his allergy list. That was, of course, well after the surveyors had left.

The Administrative Law Judge believes that the citation is supported because the itching was bothering the resident, it was interfering with his sleep, and there is no indication that he was aware that he could have it on an as needed basis, nor did the staff appear to be aware of that either.

F-314, Resident 14

42 CFR § 483.25(c) relates to pressure sores. It provides that based on a comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The State Operations Manual Guidelines were revised in November of 2004, but the Department did not implement the revisions until May 31, 2005 in order to allow for training of both providers and surveyors. Representatives from St. John's Lutheran Home attended the training on April 25, 2005.¹⁵ Frequent repositioning is a common, effective intervention for an individual with a pressure ulcer or who is at risk of developing one. Repositioning is especially important for residents who are immobile or dependent upon staff. The Department raised concerns about both her repositioning and her nutrition. The facility's plan and implementation concerning repositioning was adequate, but its actions regarding nutrition were not.

Resident #14 was a 77 year old woman who had multiple diagnoses that would put her at risk for developing pressure ulcers, including lung cancer, malnutrition, and rheumatoid arthritis which caused pain when she was in certain positions.

Resident #14 entered the facility without any pressure sores. A quarterly MDS dated Feb. 18, 2005 indicated that she had no pressure ulcer, but that she did require extensive assistance with bed mobility and the facility had placed a pressure reducing device in her bed (but not her wheelchair).¹⁶

On March 12, 2005, for the first time, there was an indication of a pressure ulcer. The interdisciplinary progress notes report "aide reported small red area on tailbone. Will observe when she requests bedpan."¹⁷

The next day, March 13, the patient complained of pain in her coccyx area, and it was noted that the area was reddened, but not opened. Duoderm was applied for comfort. There were no complaints on the 15th, 16th, 17th, 18th, or 20th, but on the 21st, it was reported that resident had a Stage 2 pressure ulcer to the coccyx, measuring 1 cm. x 1.2 cm., 0 depth, 0 drainage noted. Duoderm was placed in the area, and a pressure flow sheet was filled out.¹⁸ By March 19, 2005, there was a 1 cm. diameter open area in the sore.¹⁹ Duoderm was continued on a daily basis throughout April 2005. It also

¹⁵ Department Exs. I-39 and I-40.

¹⁶ Department Exs. K-5 and K-7.

¹⁷ Facility Exs., p. 75.

¹⁸ Facility Exs., p. 77.

¹⁹ Facility Exs., p. 127.

continued throughout May of 2005, on a daily basis. It was also applied on a daily basis throughout June.²⁰

On May 5, 2005, an MDS was prepared which noted a Stage 2 pressure ulcer and a variety of responses, including a pressure relieving device for her chair, as well as her bed, a turning/repositioning program, nutrition or hydration intervention, ulcer care, application of dressing, and other preventative or protective skin care measures.²¹ A resident assessment protocol summary dated May 9, 2005, indicated pressure ulcers, and a care planning decision. The trigger analysis of May 5, indicates that a Stage 2 pressure ulcer was present. This form also noted weight loss, and that she leaves 25% or more of her food uneaten at most meals. A May 9, 2005 Nursing RAP Summary indicates that she does have a pressure ulcer on her coccyx area, but that it is healing with a hydrocolloid dressing. She is repositioned at least every two hours. Her nutritional intake has been poor, but has improved since she was starting with the medication Megace. She also receives nutritional supplements. She has a pressure-reducing mattress on her bed and a cushion on her wheelchair. Her skin is monitored during cares and baths for areas of irritation and breakdown. The plan of care includes goals that the open area will heal without complications and that she will not develop any other open areas.²² Her care plan, as of September 3, 2004, noted that she was at risk for skin breakdowns. On March 22, 2005, an addition was made indicating that a pressure ulcer had formed, and that hydrocolloids would be applied and a pressure ulcer flow sheet would be initiated.²³ By June 16, 2005, there were three pressure ulcers.²⁴ This resident received appropriate repositioning and her pressure sores were properly treated.

Resident #14 suffered from malnutrition, and lost at least 30 pounds after being admitted to the facility. On May 5, 2005, well after the first pressure ulcer had developed, a dietary assessment was completed. The dietitian incorrectly calculated the resident's protein needs because the dietitian did not take into account the fact that the resident had pressure ulcers that would require additional protein for healing. The resident liked Ensure, but that only provides nine grams of protein in eight ounces. The resident should have had 54 to 67 grams of protein daily. In addition to Ensure, the resident should have had some other high protein supplement to promote the healing of the pressure ulcers.²⁵ This failure in the nutritional area supports the citation.

F-314, Resident #16

Resident #16 is a 90-year old woman who was admitted to St. John's from the Mayo Clinic. She had been brought to the Clinic because she had fallen. The Clinic determined that she had a neck fracture (along with other problems), and they fitted her with an Aspen Cervical Collar in order to immobilize her neck.

²⁰ Facility Exs., p. 164.

²¹ Facility Exs., p. 33.

²² Facility Exs., p. 41.

²³ Facility Exs., p. 106.

²⁴ Department Ex. K-43a.

²⁵ Department Exs. K-46, K-47, K-50a, and K-57.

Upon admission to St. John's, a temporary care plan was prepared, which indicates "cervical collar on at all times."²⁶ The physician's orders of that same date indicate "Aspen collar on at all times."²⁷ The staff routinely checked to make sure that the resident was wearing the collar, but did not check for any skin irritation resulting from the collar.

On June 20, 2005, a friend of the family asked a nurse to put a soft cloth down the front of the resident's neck brace.²⁸ On June 24, 2005, the resident complained of pain when swallowing. She told a nurse that her brace moves around some and now it hurts to swallow. The nurse noted edema around the resident's chin. The nurse attempted to look under the brace, but the resident would not allow it because it caused discomfort. The nurse reported all this to the attending physician, who ordered that the resident be taken to the hospital. When she arrived at the hospital, it was discovered that she had cellulitis and a slit in her skin caused by the brace. She was treated in the emergency room, and then moved to a regular room, and returned to St. John's two days later. The hospital dismissal summary for June 26, 2005 directs that bactroban be applied to the scab on her neck and that it be covered with gauze. The front of the collar was to be opened and removed to air out, inspect, and make dressing changes so long as the patient was lying or reclining and was at rest at the time of removal.²⁹

Medical devices are known to cause pressure ulcers to develop. The state operations manual specifically notes that cervical collars can cause pressure ulcers.³⁰ The SOM emphasizes the importance of regular skin assessments on at-risk residents. Such assessment was not done of the skin under the cervical collar for Resident #16. Neither the temporary care plan nor the nursing assistant assignment sheet directed staff to check under the collar for skin integrity. Failure to regularly check the skin under the cervical collar allowed the cellulitis to develop, and resulted in the hospitalization. The citation is supported.

Citation F-324 for Resident #20

Resident #20 is a 94 year old woman suffering from significant cognitive impairments including dementia, both short term and long term memory loss, and a variety of similar problems. Of particular importance, however, was a substantial history of falls. Part of the reason for these falls was her forgetting to use her walker. The resident had been assessed for her fall risk in December of 2004, March of 2005, and June of 2005. She was assessed with scores of 19, 19 and 17, respectively, on a scale where 10 or more represents high risk.³¹

²⁶ Department Ex. L-10b.

²⁷ Department Ex. L-7.

²⁸ Department Ex. L-16a.

²⁹ Department Ex. L-20a.

³⁰ Department Ex. I-9.

³¹ Department Ex. O-25a.

The record is replete with reports of falls in 2004 and 2005, along with staff's ideas of how to prevent them in the future. The facility had implemented a variety of interventions in response to her falls, but yet the falls continued.

Back in 2004, the resident had been treated for a urinary tract infection and the resident fell four times in just a few days, alerting the facility to the fact that she might experience frequent falls when she was ill. Then in June of 2005, she again experienced a urinary tract infection, and again was treated with antibiotics. The antibiotics began on the evening of June 24. The next day, June 25, the resident fell in an adjoining bedroom. She was unable to explain how it happened. However the staff surmised that possibly her elevated temperature due to the UTI had made her weak. The staff kept her on a 1:1 status until she went to sleep that night. The next day, the staff noticed that she appeared to be having an allergic reaction to the antibiotic, and on June 27 it was decided to switch her antibiotic to a different one. The next day, June 28, in the early afternoon, the resident fell while attempting to transfer herself from her wheelchair to a chair in the porch. Again, she was unable to explain how or why it happened. Later, that same night, the resident was found lying on her bedroom floor with blood around her head. An ambulance was called, and she was taken to the emergency room, where a minor closed head injury and scalp laceration were diagnosed.

This resident preferred to sleep in a recliner, rather than in bed. The facility used a clip alarm when the resident would lay down in the recliner for the night, but on the evening of June 28, the resident had unclipped her alarm. The alarm actually sounded, but a blanket had been tossed over it so that it was difficult to hear outside of the room.³²

On June 30, 2005, the interdisciplinary team review/reassessment resulted in a decision to take the resident's wheelchair out of sight and allow her to walk if steady enough and use the wheelchair only for transport. The team also decided to order a P.T. screen due to her unsteadiness and recent falls.³³ This occurred after the surveyors had raised questions about the resident's fall the previous night.

The citation is supported by the facts. The facility should have taken additional precautions to prevent (or at least substantially reduce the risk) of additional falls.

Citation F-324, Resident #23.

Resident #23 is an 83 year old man suffering from Alzheimer's disease, alcoholic psychoses, confusion and anxiety. He was admitted to St. John's from Bethel, where he was a known wanderer. He was admitted to St. John's in November of 2004, and was placed in the Sheltering Arms secure unit. His temporary care plan noted his wandering and called for a clip alarm for his bed as well as a wander guard (an ankle or wrist bracelet that sets off an alarm when the bracelet comes in proximity to the

³² Facility Exs., p. 57.

³³ Facility Exs., p. 45.

sensor.)³⁴ On May 12, 2005, a change of status RAP summary was prepared because the resident's behaviors had deteriorated. He was not always able to find his own room, or know where he was. He became sidetracked on his way to meals and wandered off. He also became more aggressive toward staff. He would go in and out of other resident's rooms, and was becoming less amenable to redirection. Multiple medications for dementia and hypotension sometimes caused him to have an unsteady gait and balance problems, leading to falls.³⁵

Just past midnight on June 29, 2005, the resident was found on the floor near the 1st North nurse's station. He complained about back pain, was taken back to his room, and was fine for the rest of the night. In a Fall Report and Assessment form, it was noted that he currently uses a clip alarm as a fall intervention, but there is no check mark to indicate that the alarm was activated that night. The report indicates that the resident usually gets up during the night for a snack. That night, he had eaten a sandwich within an hour before his fall. The report suggested the resident may have fallen asleep and fell to the floor while he was at the nurse's desk, but that nobody witnessed the fall. He had already been toileted and taken back to his room and put to bed around 11:30 p.m. (roughly 45 minutes before the fall). The form notes that after the fall, he was taken back to bed and "put clip alarm back on him."

The Department argues that this data suggests that the facility failed to have the clip alarm on the resident when he was taken to bed at 11:30 p.m. because there is no mention of the alarm sounding in any of the reports. The facility, on the other hand, argues that the alarm may have been put on, and may have sounded, but it just was not noted in the reports. The facility argues that the fall report's references to "put clip alarm back on him" suggests that the clip alarm was on him before the fall.

The Administrative Law Judge finds that it is more likely than not that the alarm did not sound, and that the reason that the alarm did not sound was that it was not put on him when he was put to bed before the fall. Therefore, the citation is sustained.

A.W.K.

³⁴ Facility Exs., p. 20.

³⁵ Facility Exs., p. 33.