STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z 000	COMMENTS Facility Reported Incident of 01/26/21/IL132820 COP W122 Client Protections cited	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210 350.1230b) 350.1230d)1) 350.3240a)b)e) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents, and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:	Z9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 1 d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to: 1. Implement its policy/procedure on Resident	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 2 Abuse/Neglect for R1 on 01/26/21. 2. Ensure staff immediately stopped E2 who was yelling at and hitting R1 on 01/26/21. 3. Ensure another staff at the facility was notified on 01/26/21 after E3 and E4 saw and heard E2 yelling at and/or hitting R1. 4. Ensure E2 was stopped from further yelling at and hitting of R1 and immediately removed from further contact with other clients during the evening shift on 01/26/21. 5. Ensure staff immediately notified the Administrator/designee about reported witnessed yelling and hitting of R1 by E2 on 01/26/21. 6. Ensure witness statement was completed by E3 on 01/26/21 after witnessing E2 yell at and hit R1. 7. Ensure nursing staff implemented Body Checks policy/procedure for R1. 8. Conduct a thorough investigation of the yelling at and hitting of R1 on 01/26/21. 9. Develop and implement policy on notifying licensing body when licensed staff are terminated due to substantiated abuse/neglect/mistreatment of client. These failures resulted in R1 being abused verbally and physically by E2 resulting in an injury, noted as "Minimal swelling and mild bruising to left temple area". The injury was not documented or evaluated per the Facility's Resident Abuse/Neglect Policy/Procedure	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 3 Findings include: Per Facility's Resident Abuse/Neglect Policy/Procedure provided on 5/24/21: Definitions: Abuse - any physical or mental injury or assault inflicted on a resident other than by accidental means in a facility. Abuse means: physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means and that requires (whether or not actually given) medical attention. Mental injury arises from the following type of conduct: verbal abuse refers to the use by a licensee, employee or agent of oral, written, or gestured language that includes disparaging and derogatory terms to residents or within their hearing or seeing distance, regardless of their age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threat(s) of punishment or deprivation or offensive physical contact by a licensee, employee or agent. Procedure regarding investigation of incidents of alleged abuse/neglect. 1. If a staff member suspects that an incident of abuse and/or neglect has occurred, the staff member will complete a witness statement on the form called "Staff Witness Statement for Inappropriate Interactions with Residents, Staff, and/or Visitors." This form will be immediately presented to the Nurse on duty. When the Charge Nurse receives a report, he/she is to share this with the Direct Care Coordinator immediately. 1a. Any allegation of abuse or neglect is to be reported to the Administrator immediately... 1c. Any staff member suspected of accused of abuse or neglect will be removed from duty	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 4 immediately until an investigation has been completed and a determination made regarding culpability for the alleged abuse and/or neglect. 1d. A staff member determined to have been abusive or neglectful will be terminated from Facility and reported to IDPH...resulting in the Registry being notified. 2. With any alleged abuse/injury or neglect, the Nurse on duty is to do an immediate exam/assessment. If there is suspicion of sexual or physical abuse and/or injury, the Resident is to be sent to the hospital (local) for evaluation and treatment. 2d. A summary of the incident, to be sent to IDPH within 5-days of the initial notification. The summary is to be completed by the Administrator or DON or designee. Per facility "Summary of Incident/Accident Reports And/Or Fall Reports dated 01/26/21: Summary: On the morning of 01/27/21 an allegation of mistreatment was reported to E5 (Business Operations Manager). E3 (Cleaning staff) reported to E5 that he observed a staff member putting (their) hands on a male resident (R1). Conclusion: After conducting a thorough investigation, including speaking to all individuals involved, watching camera footage and reviewing documentation, the allegation is substantiated and founded for physical abuse. E2, (Nurse) has been immediately terminated from employment at facility. Facility will follow a report with IDFPR (Illinois Department of Financial and Professional Regulations)." Facility interview with R1 on 01/27/21 confirmed R1 saying E2 "beat him up" on 01/26/21, E2 threatened to have R1 thrown in jail and the police called. E2 gave R1 ice after the incident.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 5 Facility interview with R4 on 01/27/21 confirmed the full name of nurse E2 who hit R1 hard in his bedroom and (E2) is a "bad person". Facility interview with R3 on 01/27/21 confirmed that E2 yelled at R1 after entering bedroom of R1 (and R3). R3 reported that E2 hurt her hand while in their bedroom. E2 had given ice to R1 for his head. Facility interview with E2 on 01/27/21 confirmed: 1. E2 thought R1 got upset when E2 informed him to change as E2 thought R1 had urinated on himself. 2. R1 almost hit E2 again, thinks R1 just hit his head on the wall, gave ice pack and (acetaminophen) to R1. E2 stated that R1 tried to swing at E2 who moved back, it all happened to so fast that E2 did not see anything. 3. Nothing documented on 01/26/21 regarding incident with R1 and administered Acetaminophen because E2 knew she was returning to work on 01/27/21. Facility interview with E3 (Cleaning Staff) on 01/27/21 confirmed: 1. E3 heard bedroom (door) slam shut while E3 in the washroom of R1 cleaning the mirror. 2. E3 heard E2 and R1 arguing. E3 heard E2 tell R1 "I am not scared of you." 3. R1 was lying in bed and E2 standing next to R1. 4. R1 must have said something back to E2, that is when E2 "starting puting her hands on R1." E2 punched R1 in the face more than twice. 5. R1 sat on the edge of his bed and started yelling profanities at E2. 6. E3 left the room and informed E4 (Cleaning Staff) about R1 "being beat on." 7. E4 went to R1's bedroom and R1 was yelling at	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 6 E2. E2 went to R1's room back and forth trying to calm R1 down. Facility interview with E4 on 01/27/21 confirmed: 1. E3 informed E4 about a nurse (E2) fighting with a resident (R1). 2. E4 went to R1's bedroom and saw R1 telling E2 that E2 put her hands on R1, "you put your hands on me." 3. E4 returned to the bedroom when E2 left and asked R1 if he was ok. R1's response was with profanity and "no, i am not ok. This B---- hit me." 4. E4 noted marks on R1's left side of the temple including a bump. 5. E4 noted E2 got back to R1's bedroom to take his temperature. R1 told E2 when she entered "it's going to be high because you put your hands on me." 6. E4 confirmed no (staff) was around because it was dinner. Interview with E5, Business Operations Manager, on 5/24/21 at 12:24 PM regarding training of E4 and E3 on notifying staff when they see mistreatment of clients validates the following: facility contract for cleaning services with E4 started December 2019. Facility policies on abuse/neglect, privacy, CPR, Code Blue were reviewed with E4 in December 2019. It was expected that E4 would relay the information regarding policies with any staff when coming to clean at the facility. Interview with E5 on 5/24/21 at 1:45 PM validate the following: 1. E4 (Cleaning staff) called E5 later in the evening on 01/26/21 about what E3 and E4 saw at the facility regarding R1 and a staff (E2). 2. E5 called E3 in the morning of 01/27/21 to ask for information about what E3 saw.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 7 3. E5 notified E1 (Administrator) and E8 (Residential Services Director) on 01/27/21 before E5 arrived at the facility. 4. Staff at the facility, Nurse E6 and Coordinator E10, were not informed on 01/26/21 after received call from E4. E5 was asked on 5/24/21 at 1:45 PM if E5 notified the nurse or direct care supervisor at the facility or the Administrator E1 or RSD E8 on 01/26/21 after receiving call from E4. E5 confirmed she did not notify any of them on 01/26/21. Interview with E4 on 5/24/21 at 2:15 PM validate the following: 1. E4 tried to look for someone by the nurse station to tell someone about what E3 saw but no (staff) were there except E2. 2. "It's clear something was happening, you can hear (R1's) voice in the hallway." E2 was in the room with R1. Interview with E1 and E5 on 5/24/21 at approximately 2:00 PM validate the following: 1. E5 should have notified on 01/26/21 E1, E8, the other nurse or staff at the facility about what was observed between R1 and E2. 2. E2 should have been removed from further contact with R1 and other clients on 01/26/21 after E5 was informed by E4. E1 and E5 were asked on 5/24/21 at approximately 2:00 PM regarding length of time E2 worked on 01/26/21. E1 and E5 confirmed that E2 completed the evening shift. Documentation provided confirmed E2 worked from 3:06 PM through 11:19 PM on 01/26/21. Nurse's Notes for R1 on 01/27/21 at 9:50 AM	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 8 includes "Minimal swelling and mild bruising to left temple area. (R1) denied pain upon palpitation (sic). (R1) stated it did not hurt. Did check rest of (R1's) head and nothing noted... (R1) reported it was just his head and did not have anything else." Interview with E1 on 5/24/21, at approximately 1:00 PM, regarding color and size of the bruising and swelling on R1 validated that the nursing notes do not include those information. Nurse's Notes for R1 validate that prior to the 01/27/21 9:50 AM note, the last entry was from 01/22/21. R1's Medication Administration Record (MAR) for 01/10/21 through 02/08/21 confirm: a. 3:00 PM doses of Lithium Carbonate 150 mg and Metformin Hydrochloride 850 mg were due on 01/26/21 but were not signed off, unknown if given to R1. b. 8:00 PM doses of Lactulose 15 milliliters, Senna plus 1 tablet, Simvastatin 10 mg, Tamsulosin Hydrochloride 0.8 mg were due on 01/26/21 but were not signed off, unknown if R1 received these. c. As Needed Section of the MAR of R1 confirm no entry for use of Acetaminophen for R1 on 01/26/21. Per Facility Investigation, E5 was notified of an allegation of mistreatment in the morning of 01/27/21. Interview with E5 on 5/24/21 at 1:45 PM regarding when the facility was informed by E4 of what E3 and E4 saw between E2 and R1 validate that E4 called E5 later in the evening on 01/26/21. E5 was asked if E1, E8, the other nurse on duty or the direct care supervisor at the facility were notified on 01/26/21 after receiving call from E4.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 9 E5 confirmed no calls were made to E1, E8 or facility staff on 01/26/21, notifications were made to E1 and E8 in the morning of 01/27/21. Review on 5/25/21 at 11:00 AM of the facility staffing on 01/26/21 for the afternoon shift validate there were ten other staff working in the building shortly after E3 and E4 witnessed E2 yell at and hit R1. The ten staff were Nurse E6, Direct Care Staff E9, E10, E11, E12, E13, E14, Direct Care Agency Staf E16, Dietary Staff E17 and E18. There is no interview with Nurse E6 and the nine other staff working that evening shift. This staffing information was not part of the facility's investigation summary. Interview with Residential Services Director E8 on 5/25/21 at 1:55 PM validate the following: 1. Time stamp on video footage on 01/26/21 is cut off. Video footage technician E20 was consulted on how to access the footage last Friday (5/21/21). 2. Notes taken during review of video footage is not reproducible on 5/25/21. The investigation summary do not contain information obtained from watching the video footage. 3. Medication records for other clients that E2 passed medications for on 01/26/21 were not reviewed to determine whether E2 did not document on R1's medication record only or if E2 did it for the rest of the clients assigned to her during the shift. 4. No other incident/s were reported or filed on 01/26/21 regarding E2's treatment of client/s or staff. 5. Unknown what time E3 and E4 left the building on 01/26/21. 6. Unknown when E2 first entered the room of R1, how long E2 was in the room, how many	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005995	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
Z9999	Continued From page 10 times E2 went back and forth in R1's room. 7. Unknown when E3 first left R1's room and when E3 returned to the room with E4. 8. Unknown if E1, E8, QIDP E15, Administrative Assistant E19, Business Operations Manager E5, Activity Staff E21 and E22 were in the building at this time. (B)	Z9999		