Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	R 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

(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
{S 000}	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. An onsite revisit survey was conducted on 11/19/25 through 11/20/25 for all previous deficiencies cited on 6/5/25. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant CSD: Clinical Services Director DSD: Dining Services Director ED: Executive Director Less commonly used abbreviations will be annotated in each deficiency.	{S 000}		
{S5003}	Ch 12 Sec 6 (d) Personnel and Staffing Requirements (d) Infection Control. Written policies must be in effect to ensure that newly hired and current employees do not spread a communicable disease that could be transmitted through usual job duties. These written polices must, at a minimum: (i) Ensure a safe and sanitary environment for residents and personnel; (ii) Require tuberculin testing, or screening as appropriate; and	{S5003}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David J. Lovato — TITLE: Executive Director — (X6) DATE: 12/10/2025

STATE FORM 6899 R8HW12 (Interim) — If continuation sheet 1 of 12

The plan of correction was accepted on 12/12/25. A voicemail was left with CSD Hannah. The date of correction was changed from 1/20/25 to 1/20/26 on multiple deficiencies.
Jean Lennie 12/12/25

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{S5003}	Continued From page 1 (iii) Prohibit any person with an airborne, contagious, or infectious disease from being employed until a work release is obtained. (A) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents and their food, if direct contact will transmit a disease. (B) The facility shall require staff to follow universal precautions when performing direct resident care. 1. This State Rule and Regulation is not met as evidenced by: Based on personnel file review, policy and procedure review, and staff interview, the facility failed to ensure 3 out of 5 sample employees (CNA #1, CNA #2, CNA #3) reviewed were tested or screened for tuberculosis (TB) as appropriate on an annual basis. The findings were: 1. Review of the personnel file for CNA #1 showed she was last tested for TB on 10/29/23. There was no evidence CNA #1 had been tested or screened for TB on an annual basis. 2. Review of the personnel file for CNA #2 showed she was last tested for TB on 9/8/21. There was no evidence CNA #2 had been tested or screened for TB on an annual basis. 3. Review of the personnel file for CNA #3 showed she was last tested for TB on 1/12/21. There was no evidence CNA #3 had been tested or screened for TB on an annual basis. 4. Interview with the CSD on 11/19/25 at 11:52 AM confirmed TB testing and/or screening had not been completed as required.	{S5003}		

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{S5003}	Continued From page 2 5. Review of the "TB SCREENING WYOMING - RESIDENT AND EMPLOYEE" policy, last updated April 2025, showed "The community is required to complete a community TB Risk Assessment on an annual basis to determine how often community staff should be screened for TB. All residents and employees should receive a TB risk assessment and symptom evaluation on an annual basis, or as needed."	{S5003}		
{S5007}	Ch 12 Sec 7 (b)(ii) Assisted Living Facility (ALF) Core Services (b) (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. (A) Admission orders shall include an order for TB screening, influenza and pneumococcal immunization status and orders for immunization if required, unless contraindicated. The facility must develop and implement policies and procedures to ensure the following: (I) Residents, or their legal representative are educated regarding the risks and benefits of these immunizations. (II) The immunizations are offered unless medically contraindicated or the resident is currently immunized. (III) If the resident is not vaccinated,	{S5007}		

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{S5007}	Continued From page 3 the medical record must reflect the reason, such as medical contraindication or refusal. This State Rule and Regulation is not met as evidenced by: Based on resident record review, staff interview, and policy and procedure review, the facility failed to implement their influenza and pneumococcal immunization policy for 5 out of 7 sample residents (#1, #2, #3, #5, #7) reviewed. In addition, the facility failed to ensure residents were tested for tuberculosis (TB) prior to admission for 4 out of 7 (#1, #2, #6, #7) sample residents reviewed. The findings were: 1. Review of the "IMMUNIZATION" policy, last updated April 2025, showed "...As regulations require, the community shall offer or coordinate with an outside provider for resident vaccinations and shall maintain related documentation in the electronic medical health record. The community shall determine resident's vaccination status at time of admission. After admission, the community shall coordinate for residents to receive vaccinations as required or requested. Appropriate consent (and/or refusal if required) must be obtained from resident, resident's representative, or staff member..." Review of the "TB SCREENING WYOMING - RESIDENT AND EMPLOYEE" policy, last updated April 2025, showed "...All residents and employees should have a patient TB risk assessment, symptom evaluation, and TB test performed prior to admission to the community..." The following concerns were identified: a. Review of the 11/8/25 master care plan for resident #1 showed s/he was admitted to the facility on 4/24/24, and had received a seasonal influenza vaccine on 10/27/25. Further review of	{S5007}		

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{S5007}	Continued From page 4 the resident's record showed no evidence the resident had been tested for TB prior to admission and there was no record of the resident's pneumococcal immunization status. b. Review of the 11/12/25 master care plan for resident #2 showed s/he was admitted to the facility on 9/3/24, and had declined the seasonal influenza vaccine on 10/22/25. Further review of the resident's record showed no evidence the resident had been tested for TB prior to admission and there was no record of the resident's pneumococcal immunization status. c. Review of the 10/19/25 master care plan for resident #3 showed s/he was admitted to the facility on 9/9/14 and had received a seasonal influenza vaccine on 10/9/25. Further review of the resident's record showed no record of the resident's pneumococcal immunization status. d. Review of the 9/3/25 master care plan for resident #5 showed s/he was admitted to the facility on 10/16/23 and had received a seasonal influenza vaccine on 10/27/25. Further review of the resident's record showed no record of the resident's pneumococcal immunization status. e. Review of the 10/21/25 master care plan for resident #6 showed s/he was admitted to the facility on 10/13/25. Further review of the resident's record showed no evidence the resident had been tested for TB prior to admission to the facility. f. Review of the 10/21/25 master care plan for resident #7 showed s/he was admitted to the facility on 10/13/25 and had declined the seasonal influenza vaccine. Further review of the resident's record showed no evidence the resident had been tested for TB prior to admission to the facility and there was no record of the resident's pneumococcal immunization status. g. Interview with the CSD on 11/19/25 at 2:15	{S5007}		

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{S5007}	Continued From page 5 PM confirmed no further documentation was available.	{S5007}		
{S5026}	3. Ch 12 Sec 7 (j)(ii) Assisted Living Facility (ALF) Core Services (j) (ii) There must be an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome and sanitary in accordance with the rules. The dietetic service must ensure that food prepared in nutritionally adequate in accordance with the Dietary Reference Intakes (DRI) for adults. This State Rule and Regulation is not met as evidenced by: Based on observation, review of manufacturer's instructions, staff interview, and review of the FDA 2022 Food Code regulations, the facility failed to ensure food was prepared, stored, and distributed under sanitary conditions in 1 of 1 kitchen. The census was 53. The findings were: Related to temperature monitoring of food storage units: 1. Observation on 11/19/25 at 10:29 AM showed the kitchen used a walk-in refrigerator and freezer for food storage. The following concerns were identified: a. Review of the August 2025 "Refrigeration Temperature Log" sheet showed the temperature of the refrigerator and freezer were not documented on 11 of 31 days (8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, 8/31).	{S5026}		

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{S5026}	Continued From page 6 b. Review of the November 2025 "Refrigeration Temperature Log" sheet showed the temperature of the refrigerator and freezer were not documented on 13 of 19 days (11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/10, 11/13, 11/14, 11/15, 11/16, 11/17). 2. Interview with the DSD on 11/19/25 at 11:54 AM confirmed the temperatures of the food storage units had not been documented as required. Related to the sanitary environment of the kitchen: 1. Observation on 11/19/25 at 10:29 AM showed the facility used a Scotsman ice machine. The following concerns were identified: a. A maintenance sticker on the side of the ice machine showed the ice machine had last been serviced on 4/11/24. Further observation showed the exterior air vents and the screen filter behind the air vents, were covered with grease and debris. b. Review of the November 2025 "Cooks' Cleaning Schedule" showed the task of cleaning the ice machine was checked off as completed for both the first and second week of November. c. Interview with the DSD on 11/19/25 at 11:54 AM confirmed the ice machine had not been cleaned. In addition, the DSD stated she had attempted to arrange for service of the ice machine; however, the service company had not responded. Further, the DSD revealed she was going to educate the dietary staff on not marking a cleaning task as complete before the task was finished. d. Review of the Ice-O-Matic manufacturer's instructions, provided by the facility, showed the following maintenance should be performed every	{S5026}		

Healthcare Licensing and Surveys

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{S5026}	Continued From page 7 3 months "1. Clean the ice-making section, if necessary, per instructions on page 10. Local water conditions may require that cleaning be performed more often than 6 month intervals. 2. Check ice bridge thickness...3. Check the water level in the trough...4. Clean the condenser (air cooled machines) to insure (sic) unobstructed air flow. 5. Check for leaks of any kind; water, refrigerant, oil, etc. 6. Check the bin switch or the thermostat for proper adjustment...7. Check the Cam Switch for proper adjustment...8. Check the water regulating valve (water cooled machines for proper adjustment...9. Check all electrical connections. 10. Oil fan motor if motor has oil fitting (self-contained air cooled)." 2. Observation of the kitchen on 11/19/25 at 10:29 AM showed the automatic dishwasher had a data plate which showed the minimum temperature of the rinse and wash water should be 120 degrees Fahrenheit and the minimum concentration of the chlorine should be 50 parts per million. The following concerns were identified: a. Review of the November 2025 dishwasher/sanitizer concentration log sheet showed the temperature of the water and sanitizer solution were to be record at breakfast, lunch, and dinner. Further review showed the temperature and sanitizer concentration were not documented 16 out of 108 opportunities. b. Interview with the DSD on 11/19/25 at 11:54 AM confirmed the temperature of the water and sanitizer concentration for the dishwasher had not been documented as required. 3. According to the 2022 FDA Food Code "2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that...(J) FOOD EMPLOYEES are properly maintaining the	{S5026}		

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{S5026}	Continued From page 8 temperature of TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during thawing through daily oversight of the FOOD EMPLOYEE'S routine monitoring of FOOD temperatures..." 4. According to the 2022 FDA Food Code showed "4-602.11 Equipment Food-Contact Surfaces and Utensils...Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms. Some equipment manufacturers and industry associations, e.g., within the tea industry, develop guidelines for regular cleaning and sanitizing of equipment. If the manufacturer does not provide cleaning specifications for food-contact surfaces of equipment that are not readily visible, the person in charge should develop a cleaning regimen that is based on the soil that may accumulate in those particular items of equipment." 5. According to the 2022 FDA Food Code showed "4-703.11 Hot Water and Chemical. Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in	{S5026}		

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{S5026}	Continued From page 9 combination with time to achieve sanitization...The actual temperatures and rinse pressure should be consistent with the machine manufacturer's operating instructions and within limits specified in §§ 4-501.112 and 4-501.113. If either the temperature or pressure of the final rinse spray is higher than the specified upper limit, spray droplets may disperse and begin to vaporize resulting in less heat delivery to utensil surfaces. Temperatures below the specified limit will not convey the needed heat to surfaces. Pressures below the specified limit will result in incomplete coverage of the heat-conveying sanitizing rinse across utensil surfaces."	{S5026}		
{S5041}	Ch 12 Sec 7 (l) Assisted Living Facility (ALF) Core Services (l) Quality Improvement. (i) The facility shall have an active quality improvement program to ensure effective utilization and delivery of resident care services. (A) A member of the facility's staff shall be designated to coordinate the quality improvement program. (B) The quality improvement program shall encompass a review of all services and programs provided for all residents. the program shall have: (I) A written description; (II) Problem areas identified; (III) Monitor identification;	{S5041}		

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{S5041}	Continued From page 10 (IV) Frequency of monitoring; (V) A provision requiring the facility to complete annually a self-assessment survey of compliance with the regulations; and (VI) A satisfaction survey shall be provided to the resident, resident's family, or resident's responsible party at least annually. (C) Problems identified during the annual survey or the quality improvement process shall be addressed with appropriate written corrective actions. (D) The quality improvement program shall be re-evaluated at least annually. This State Rule and Regulation is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to have a system in place to address problems identified during a licensure survey conducted on 6/5/25 and failed to complete a self-assessment survey of compliance with the regulations on an annual basis. The census was 53. The findings were: 1. Review of the facility's documentation showed no evidence a self-assessment of compliance with the regulations had been completed. 2. Review of the facility's quality assurance (QA) documentation showed for following concerns: a. Review of the July 2025 QA documentation showed no evidence the deficiencies cited related to tuberculosis testing or the kitchen were included.	{S5041}		

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{S5041}	Continued From page 11 b. Review of the August 2025 QA documentation showed no evidence the corrective actions, proposed on the plan of correction following the 6/5/25 licensure survey, were being monitored. c. The September 2025 and October 2025 sections of the QA binder failed to include any documentation. 2. Interview with the assistant executive director on 11/19/25 at 3:22 PM after a telephone consultation with the ED, confirmed no further documentation was available.	{S5041}		
{S5060}	Ch 4 Sec 5 (j)(e) Licensure (j) (E) The Assisted Living Facility shall post the survey results in a manner conducive for public view. This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to post the state licensure survey results in a manner conducive for public view. The census was 53. The findings were: 1. Observation of the facility during the survey timeframe of 11/19/25 through 11/20/25 showed no evidence the state licensure survey results were available for public view. 2. Interview with the assistant ED on 11/19/25 at 3:56 PM revealed the interim ED had found the survey binder in the activity room and had given it to her because he did not know where it belonged.	{S5060}		

Facility Name:
Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009
Survey Date:
11/20/2025
Tag Number:
{S5003}

Upon notification of the deficiency, the facility will do the following:

CSD will conduct and document communicable disease risk assessments for the three identified employees by 1/20/2026

Ensure each assessment will be placed in a binder under December

To ensure compliance moving forward, the facility will take the following actions:

New hire checklist will be updated to include TB testing on or before start date.

A TB Program Binder has been put together by month dividers.

Each employee will be audited for a current TB test, and a copy will be placed in the binder under the month that the assessment will be due yearly.

Training will be completed with all supervisory staff by 1/20/2026 JY outlining the requirement and proper documentation procedures.

To ensure continued compliance:

Business office manager, CSD or ED will complete monthly random audits of at least 10% of personnel within the TB Binder for the next 6 months, ensuring the risk assessment form is present and current.

Audit results will be reviewed quarterly by the ED and CSD

After six months, the monitoring schedule will transition to quarterly audits as part of the facility's ongoing quality assurance program.

Date of Completion

All corrective actions will be fully implemented by:

1/20/2026 JY

Accepted 12/12/25
Jan Yonni

Facility Name:
Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009
Survey Date:
11/20/2025
Tag Number:
{S5007}

Upon notification of the deficiency, the facility will:

The facility will review the records of all residents cited and complete the following.

TB screening: Any resident lacking documented TB screening prior to admission has will receive a TB risk assessment and TB testing per state requirements. Results will be entered into the resident's electronic record.

Immunization Documentation: Each cited resident's chart will be updated to include influenza status, pneumococcal status, and refusal or medical contraindication documentation.

Missing Pneumococcal Immunization Status: For residents without documented pneumococcal vaccine status, clinical staff will obtain records from primary care providers or immunization registries. If no record can be obtained, residents will be offered the vaccination, and consent or refusal will be documented.

These corrective actions will be completed by 1/20/2026 JY

Measures taken to identify other residents who could be affected:

A facility-wide audit of all current residents will be completed to ensure compliance with:

Documented TB screening prior to admission, Influenza immunization status (including consent, declination, or contraindication), Pneumococcal immunization status, including consent, declination, or contraindication.

Any missing documentation will be obtained and recorded. Any residents without vaccine status available will be offered immunizations, with consent or refusal documented.

The audit will be completed 1/20/2026 JY

To ensure continued compliance:

Revised admission process:

A new admission immunization & TB Screening Checklist has been developed and must be completed before admission is finalized.

JY 12/12/25

ED, and the CSD must verify:

TB risk assessment and TB test completed, Influenza status documented and offered if due, Pneumococcal status documented and offered if due, Consent/refusal appropriately recorded.

All appropriate staff will receive training on:

State requirement, new admission checklist, proper immunization and TB documentation procedure, how to document refusals and contraindications accurately.

Training will be completed by 1/20/2026 JY

Monitoring:

To ensure sustained compliance, the facility will implement the following monitoring plan:

The CSD will audit 100% of all new admissions for 60 Days to ensure TB screening and immunization requirements are fully completed and documented.

After 60 days, the facility will audit 25% of new admissions monthly for 6 months

Results will be reviewed during the QAPI meetings.

Monitoring will continue until the QAPI committee determines the issue is fully corrected and stable.

Completion Date:

All corrective actions will be completed by 1/20/2026 JY

JY 12/12/25

Facility Name:

Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009

Survey Date:

11/20/2025

Tag Number:

{S5026}

Upon notification of the deficiency, the facility will:

The Regional Dining Services Director will provide training to Executive Director, Dining Director and dining services staff concerning refrigeration temperature logs.

The Dining Services Director will provide temperature logs for each walk in and insure thermostats are in proper working conditions with proper placement.

The Executive Director will audit Dining Departments compliance of walk-in cooler and freezers daily for 1 month, then weekly on-going audits with 10-minute sanitation checklist.

Date of completion: 01/20/2026

Measures taken to identify other residents who could be affected:

The Regional Dining Services Director will provide education to Executive Director, Dining Director, Dining services and Environmental staff concerning proper equipment cleaning.

The Regional Environmental specialist will educate Executive Director, Dining Director, and Environmental staff concerning a consistent scheduled preventative maintenance plan.

The Dining Service Director will update and provide cleaning logs that addresses proper cleaning of all equipment.

The Regional Environmental specialist will help contract local HVAC vender to provide routine preventative maintenance as required.

The Executive Director will audit Dining Departments compliance of all cleaning logs daily for 1 month, then weekly on-going audits with 10-minute sanitation checklist.

Date of completion: 01/20/2026

Upon notification of the deficiency, the facility will:

The Regional Dining service Director will provide education to Executive Director, Dining Director and Dining Services staff concerning dish machine water temperature.

The Dining Service Director will provide Dish temperature logs and ensure thermostats are in proper working condition.

The Executive Director will audit Dining Departments compliance of dish machine temperature logs daily for 1 month, then weekly on-going audits with 10-minute sanitation checklist.

JY 12/12/25

Date of completion: 01/20/2026

Measures taken to identify other residents who could be affected:

The Regional Dining Services Director will provide education to Executive Director, Dining Director and dining services staff concerning PPM chemical compliance.

The Dining Service Director will provide test strips and PPM logs for proper recording of chemical saturation.

The Executive Director will audit Dining Departments compliance of PPM Chemical logs daily for 1 month, then weekly on-going audits with 10-minute sanitation checklist.

Date of completion: 01/20/2026

SY 12/12/25

Facility Name:
Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009
Survey Date:
11/20/2025
Tag Number:
{S5041}

Upon notification of the deficiency, the facility will:

The facility will take corrective steps to re-establish and document its QAPI processes:

The ED and CSD will review all outstanding corrective actions from the previous survey plan of corrections.

Each prior corrective action item will be reviewed for completion.

All completed actions will be entered into the Facility's QAPI tracking log and stored in the QAPI Binder

Measures taken to identify residents or areas potentially affected

Because an inactive or undocumented QAPI program affects all residents, the facility will conduct a facility wide review:

All current QAPI logs, audits meeting minutes, corrective action plans, and follow-up documentation from the past 12 months were reviewed

Any incomplete or missing follow-up items will be identified and addressed

Departments (nursing, dietary, housekeeping, activities, maintenance) will be asked to submit any outstanding issues or trends requiring QAPI intervention.

Any corrective actions arising from this review will be added to the 2025 QAPI plan and assigned to responsible staff.

This review will be completed by 1/20/2026 JY

To ensure the QAPI program remains active, ongoing, and fully documented, the facility has implemented the following:

A new QAPI Binder will be created and updated, required monthly meetings for 3 months then quarterly meetings, required documentation of meeting minutes, and required tracking of each corrective action item until completion.

A meeting template will be utilized to ensure consistent documentation

JY 12/12/25

Ed will provide training to department heads on:

How to document corrective actions

How to perform follow-up audits

How to submit QAPI data monthly

Their role in the QAPI Program

Training will be completed by 1/20/2026 SY

A centralized binder will be created to store:

All QI meeting minutes

Audit results

Corrective action tracking logs

Previous PoCs and follow-up verification

Ongoing monitoring tools

To verify that the QAPI Program remains active and properly documented:

The ED will conduct monthly reviews of all QAPI documentation to ensure:

Meeting minutes are completed

All actions are tracked until resolved

Monitoring evidence is attached

The ED will perform a quarterly audit of the entire QAPI program to ensure compliance.

Quarterly QAPI audit results will be reviewed in the QAPI Committee and used to identify new improvement priorities

Monitoring will continue indefinitely or until the QAPI committee determines sustained compliance is achieved.

Completion Date

All corrective actions will be fully implemented by

1/20/2026 SY

SY
12/12/25

Facility Name:
Sierra Hills Assisted Living Community, 4606 N. College Dr. Cheyenne, WY 82009
Survey Date:
11/20/2025
Tag Number:
{S5060}

Upon notification of the deficiency, the facility will:

The facility will post the most recent survey results in a binder within the main entrance lobby

When new survey results are received, the ED will ensure they are posted within an appropriate amount of time.

To ensure compliance:

The ED will audit monthly and then quarterly that the most current survey results are posted.

Findings will be reviewed quarterly during QAPI meetings.

Completion Date

All corrective actions will be fully implemented by

1/20/2025 JY

David J. Lovato Executive Director (Interim) 12/10/2025

JY 12/12/25