Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967960	A. BUILDING: _____ B. WING _____	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIFE CARE INC	1074 C/D HYACINTH PLACE WELLINGTON, FL 33414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Change of Ownership (CHOW), Generator Monitoring and Complaint (#2026010570) survey conducted on - at Golden Life Care, Inc. Deficiencies were identified related to the CHOW at the time of the survey.	A 000		
A 008	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the	A 008		

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A 008	Continued From page 1 facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or	A 008		

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A 008	Continued From page 2 her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be transmitted to other residents or staff,	A 008		

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A 008	Continued From page 3 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded	A 008		

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A 008	Continued From page 4 on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the Resident Health Assessment ((Agency for Healthcare Administration (AHCA) Form 1823) based on a to examination by a licensed health care provider was fully completed for 1 of 2 sampled residents as required.	A 008		

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A 008	Continued From page 5 The findings included: On a record review of resident #3 file revealed an admission date of . Further review of the Health Assessment (Agency for Healthcare Administration (AHCA) Form 1823) dated revealed missing required documentation as follows: In the Facility information section on the Health Assessment (AHCA Form 1823); no Fax Number, no contact Person. These fields are mandatory to ensure complete identification of the facility and responsible personnel. The Special Diet Instructions were missing required Details, The form indicated "Other (Mechanical Soft)" under Special Diet Instructions, but the provider did not specify the required consistency (e.g., chopped, ground, puree). Lack of specificity prevents accurate dietary planning. Conditions/Requirements Section was Not Completed All Mandatory Yes/No determinations were left blank, including: Communicable , Bedridden status, , 3, or 4 , , Danger to self or others, Requirements for 24 hour nursing or , care. Failure to complete these items prevents determination of care needs and risks essential for safe placement. The Placement Appropriateness Not Indicated, The provider did not select YES or NO regarding whether the individual's needs can be met in an Assisted Living Facility. This determination is required prior to admission or continued stay.	A 008		

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A 008	Continued From page 6 During an interview with the Manger and the Administrator on at approximately 2:00 PM they acknowledged the finding. The facility provided no additional information for review at the time of the survey. Class III	A 008		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his	A 052		

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A 052	Continued From page 7 or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , ,. converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of	A 052		

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A 052	Continued From page 8 administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the	A 052		

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A 052	Continued From page 9 resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure when unlicensed medication technician staff assist residents with self-administration of	A 052		

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A 052	Continued From page 10 medication that the medication labels are read in the presence of the residents, that the correct frequency as ordered by physician, medication labels and applicable Florida Regulations are followed. The findings included: On medication rounds were observed with Staff B (Medication Technician/Unlicensed Staff) at 9:30 AM and 4:45 PM while providing assistance with the self-administration of medications to the residents. No observations of Staff B reading the medication labels in the presence of the residents as required. The following residents were observed receiving their medications from Staff B without a verbal identification of the medication. Observation on at 9:45 AM of Staff B placing oral medications , 5mg, , 20mg, And , 50mg into cup for Resident #5, medications were not announced. Observation on at 4:45 PM of Staff B prepared medication for Resident #4, , 500mg, 10mg, , 25mg, and , medications were not announced. Observation on at 5:00 PM of Staff B prepared medication for Resident #6, 5mg, , 7.5mg, 5mg, and 40mg, medications were not announced. Observation on at 5:15 PM of Staff B prepared medication for Resident #7, , 650 mg, , 125	A 052		

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A 052	Continued From page 11 mg, 100mg, 100mg, and Oanzapine 5mg, medications were not announced. During an interview on at approximately 5:30 PM these findings were reviewed and acknowledged by the Administrator and the Manager. Resident #4 On at approximately 4:45 PM, Staff B, an unlicensed staff member, was observed assisting Resident #4 with her scheduled medications. During the observation, Staff B retrieved the resident's medication, , , , and , , and placed them in small plastic bag, where medications were then crushed and mixed with apple sauce in a small cup. Staff B than brought the prepared medications to the Resident in the Dining area, she then spoon fed the medication directly into the resident's . The resident did not participate in the medication administration process. Staff B did not provide verbal identification or explanation of each medication to the resident prior to administering it. During an interview on at approximately 4:55 PM Staff B stated that this was the daily routine followed for Resident #4. On at 5:00 PM Staff B was observed assisting Resident #4 with , , medication, . Review of the MOR shows, instill 1 drop in both , every eight hours (,), and documented that the resident 4 received the medication at 8:00AM and 12:00PM.	A 052		

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A 052	Continued From page 12 During an Interview on 08/102026 at 5:15 PM she stated that she gives the Resident the , , during the medication rounds at the times identified on the MOR 8:00 AM, 12:00 PM, 6:00 PM. During an interview on at approximately 5:30 PM with the Manager the findings were reviewed and she acknowledged the findings, additionally she stated that the facility did not have a waiver signed by the resident or the resident's representative requesting that medications not be verbally identified at the time they are provided. Resident #7 On at approximately 5:15 PM, during medication rounds, Staff B (Medication Technician) was observed retrieving the medication, , for Resident?#7. The medication label specified: Take 1 tablet by every 8 hours for , . A review of the Medication Observation Record (MOR) for Resident?#7 confirmed the same order: Take 1 tablet by every 8 hours for , . However, further review revealed documentation on the MOR indicated that the resident was receiving only two doses per day (morning and bedtime), the Facility was failing to administer the prescribed third dose to meet the eight-hour interval. During an interview conducted at 5:15 PM, with Staff B (medication Technician) she acknowledged that Resident?#7 is only receiving two doses of the medication daily and confirmed that the third dose, required to fulfill the every-eight-hour order, is not being administered,	A 052		

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A 052	Continued From page 13 stating the resident is sleeping. The facility's failure to administer , every eight hours as prescribed by the healthcare provider, and its omission of required verbal guidance to the resident, demonstrates non-compliance with the ordered regimen and violates both statutory and regulatory requirements. Resident #3 On /2-026 at approximately 5:20 PM, during medication rounds, Staff B (Medication Technician) was observed retrieving the medication . .25MG. for Resident #3. Review of the medication label and the Medication Observation Record (MOR) showed the instruction: "ake 1 tablet by every 12 hours for , at 9:00 AM and 9:00 PM. During an Interview on at approximately 5:20 PM with staff B she stated that the medication is routinely provided to the resident at approximately 5:00 PM, prior to dinner. This administration time does not follow the scheduled dosing instructions of every 12 hours at 9:00 AM and 9:00 PM as ordered by the physician. The facility did not ensure staff followed the prescribed medication schedule when assisting with self administration of medication. . Additional observation during the medication round on at 4:45PM before dinner, The following Residents were receiving medications with the labels showing instructions	A 052		

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A 052	Continued From page 14 to give once daily at bedtime, Resident #4 Medication FUM 25MG TAB, Take one tablet by each night at bed time. Resident #6 Medication 5MG TAB, Take 1 tablet by every night at Bedtime (sleep) 7.5MG NTAB, Take 1 tablet by once daily at bedtime ( ) Resident #2 Medication HYDR 5MG TAB, Take one tablet by each night at bedtime (memory) During an interview on at 9:30 AM with Resident #6 she stated that she does to bed at night about 8:30 PM. During an interview on at 10:30 AM with Resident #7 she stated that she does to bed at night about 8:00 PM. During an interview on at approximately 5:00 PM with Staff B she stated that the medication rounds are completed before and during dinner starting at 4:45 PM as all the residents want to go to bed early. This practice does not comply with the ordered dosing times The residents reported that their usual bedtime is approximately 8:30?PM. Providing this medication at 5:00?PM is inconsistent with the bedtime instruction. Class III	A 052		

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	AL11967960	A. BUILDING: _____ B. WING _____	08/11/2026

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A 054	Continued From page 15	A 054		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ˘ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and an interview, it was determined that the facility failed to ensure the Medication Observation Record (MOR) was completed as required for 1 of 1	A 054		

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A 054	Continued From page 16 sampled residents (Residents #7) who require assistance with self-administration of medication. The findings included: On at approximately 5:15 PM during medication rounds observation of resident 7 MOR revealed her morning dose of medication , 5mg was not documented on as given to , 5mg was provided daily as evidenced by the bubble pack of the medication supply missing pills. Additional interview with Staff B, confirmed that the resident 7 has been receiving the medication and staff forgot to document. Further review of the MOR revealed documentation that the resident had received medication , 2.5mg daily from to , however there was no evidence that the medication was available. Staff A was notified of these findings during interview on at 10:50 AM. The facility provided no additional documentation for review at this time. Class III	A 054		

Agency for Health Care Administration

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ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

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ZZ875	Continued From page 1	ZZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,

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ZZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	ZZ875		

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ZZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility, who advertises special care to residents with 's or related (ADRD) and is a secured facility, failed to ensure that 2 of 3 sampled staff (Staff A, and B) completed the one hour training video from the Department of Elder Affairs within 30 days of hire and the additional required training in and related forms of . The findings included: During an interview conducted on at approximately 11:00 AM with the Administrator	ZZ875		

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ZZ875	Continued From page 4 she acknowledged that the facility advertises that it provides care for residents diagnosed with A review of Staff A, the Administrator) file and documents revealed that she has a hire date of , supervises and provides direct care to the residents. Review of her file did not reveal documentation that she had completed the 1-hour training video, and the additional 3-hour training, and 4-hour training as required for staff interacting with or providing personal care to a participant. A review of Staff B, (Medication Technician/Care Giver) documents revealed that she has a hire date of and provides direct care to residents. Review of her file did not reveal documentation that she had completed the 1-hour training video as required for staff interacting with or providing personal care to a participant. During an interview with the Administrator on at 2:00 PM she acknowledged that the training was not completed, this surveyor informed her of the training requirements. No additional information was provided. Class III	ZZ875		