DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING _____ B. WING _____	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(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) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow a bowel protocol for 1 of 6 sampled residents assessed for bowel movements (Resident #77). The findings included: Resident #77 was admitted to the facility on 03/13/13 with diagnoses which included bilateral femoral fractures, atrial fibrillation, dementia, anxiety and congestive heart failure. Review of Resident #77's most recent Annual Minimum Data Set (MDS) dated 06/18/13 revealed she had difficulty understanding others, making herself understood and hearing loss. The MDS documented Resident #77 was incontinent of bowel and bladder and needed extensive assistance with toileting. Further MDS documentation noted she used a wheelchair for mobility and moved on and off the toilet only with staff assistance. Review of physician orders dated for the month of July 2013 revealed the following order for constipation: Colace 100 mg capsule 2 capsules by mouth daily for constipation.	F 309	**ALEXANDRIA PLACE'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.** • F309: **ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** ALEXANDRIA PLACE ENSURES THAT EACH RESIDENT RECEIVES AND ARE PROVIDED WITH 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. ALEXANDRIA PLACE FOLLOWS A BOWEL PROTOCOL FOR RESIDENTS. THERE WAS NO HARM TO RESIDENT #77. RESIDENT #77 HAD A BOWEL MOVEMENT NATURALLY ON THE 4TH DAY. FOR RESIDENT #77, THE ADMINISTRATIVE NURSE WOULD REVIEW THE BOWEL WARNING REPORT ON A DAILY BASIS TO SEE IF STANDING ORDERS NEEDED TO BE ACTIVATED DUE TO NOT HAVING A BOWEL MOVEMENT IN THREE CONSECUTIVE DAYS. THIS PROCESS WAS DONE DAILY UNTIL 7/31/13 AS THE RESIDENT WAS DISCHARGED	8-12-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Fowler — TITLE: Administrator — (X6) DATE: 8/16/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DHSR Charlotte Branch Mail Room Received AUG 20 2013 by:

Original Signature date: 8/2/13

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F 309	Continued From page 1 Review of Facility Standing Orders on Resident #77's medical chart revealed the following for constipation: 1. Manually check for stool, if low, manually, remove stool from rectal vault. 2. Milk of Magnesium (MOM) 30 ccs every 4 hours as needed x 24 hours. a. May also use Dulcolax suppository 1 per rectum every 12 hours PRN (whenever neccessary) x 48 hours. b. May also use fleets enema one per rectum every 24 hours PRN x two 3. Colace 100 mg. two @ (at) HS (bedtime) for residents needing a stool softener. Review of Resident #77's current care plan revealed Resident #77 required the total assistance of staff with all activities of daily living, (ADL) toileting and was incontinent of bowel and bladder. In addition nurse aides would give incontinence care frequently per protocol and document the number of incontinent episodes each shift and if no bowel movement in 3 days bowel protocol was to be instituted. Review of the "Bowel and Bladder Report" for the last 30 days for Resident #77 revealed the last bowel movement (BM) documented for Resident #77 was 06/20/13 on 2nd shift and not again until 06/25/13 on 2nd shift (4 days). Review of the Medical Record for Resident #77 revealed there was no documentation the physician had been contacted regarding constipation during the time frame of 06/23/13 and 06/25/13 when the bowel report documented "Warning". Review of the nurses' notes revealed	F 309	HOME. SINCE 6/25/13, THE RESIDENT DID NOT HAVE ANY WARNINGS ON THE BOWEL REPORT AND THEREFORE DID NOT REQUIRE THE ACTIVATION OF STANDING ORDERS. **ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** ANY RESIDENT WHO DOES NOT HAVE A BOWEL MOVEMENT WITHIN THREE DAYS HAS THE POTENTIAL TO BE AFFECTED. POTENTIALLY AT RISK RESIDENTS WILL BE IDENTIFIED WITH THE USE OF THE BOWEL WARNING LIST GENERATED FROM MDS MAX AS IT REVIEWS ALL RESIDENTS FOR THEIR BOWEL MOVEMENT ACTIVITY. ANY RESIDENT WHO HAS NOT HAD A BOWEL MOVEMENT IN THREE CONSECUTIVE DAYS WILL TRIGGER ON THE BOWEL WARNING REPORT/LIST. THE ADMINISTRATIVE NURSE PULLS THE BOWEL WARNING REPORT DAILY SO THE BOWEL WARNING LIST CAN BE REVIEWED AND THE BOWEL PROTOCOL CAN BE ACTIVATED . THIS REPORT REVIEWS ALL RESIDENTS AND IDENTIFIES ANY WHO HAVE NOT HAD A BOWEL MOVEMENT FOR THREE CONSECUTIVE DAYS. FOR RESIDENTS WHO TRIGGERED ON THE WARNING LIST, THE ADMINISTRATIVE NURSE ENSURES THE BOWEL PROTOCOL IS INITIATED AS SHE PASSES THIS INFORMATION ON TO THE INDIVIDUAL RESIDENTS' NURSE. IF THE RESIDENT REPORTS HAVING A BOWEL MOVEMENT OR IF THE RESIDENT IS OBSERVED HAVING AN ADEQUATE BOWEL MOVEMENT PRIOR TO THE ACTIVATION OF THE BOWEL	

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F 309	Continued From page 2 no documentation of constipation or interventions put into place during the same time frame. Review of the physicians' orders where the standing orders for constipation were initiated revealed since admission Resident #77 had 3 additional episodes of constipation where the bowel protocol had been instituted. An interview was conducted on 07/18/13 at 4:15 PM with Nurse #1 who reviewed the Medication Administration Record (MAR) for Resident #77 and confirmed there was no documentation of the bowel protocol being put into place or laxatives administered to Resident #77 during the time frame of 06/23/13-06/25/13. Nurse #1 revealed the 2nd shift supervisor (Nurse #3) was responsible to run the "Bowel and Bladder Reports" and from those distributed to the nursing staff a sheet titled "Bowel Warnings" . This sheet listed those residents who had not had a recorded bowel movement in three days and was usually given to the 2nd shift nurses. The medication nurses were then responsible to initiate and follow through with the bowel protocol. An interview was conducted on 07/18/13 at 4:30 PM with Nurse #3. Nurse #3 reviewed the "Bowel and Bladder Report" of Resident #77 and revealed the first day of the warning of the missed bowel movement was a Sunday which she did not work. Nurse #3 went on to say the facility did have a nurse to cover the weekends and the bowel reports would have still been run but she did not know why the bowel protocol was not initiated. An interview was conducted on 07/19/13 at 9:30 AM with the Clinical Nurse who reviewed the nurse staffing schedule and revealed that	F 309	PROTOCOL, THEN IT IS DOCUMENTED IN THE MDS MAX SYSTEM AND THE PROTOCOL IS NOT ACTIVATED AS IT IS NOT NECESSARY. FOR RESIDENTS WHO TRIGGER ON THE BOWEL WARNING LIST AND THEY HAVE NOT HAD A BOWEL MOVEMENT PROIR TO THE ACTIVATION OF THE STANDING ORDER, THEIR NURSE WILL ACTIVATE THE STANIDNG ORDER. ANY RESULTS OBTAINED BY ACTIVATING THE STANDING ORDER WILL BE DOCUMENTED IN MDS MAX BY THE RESIDENT'S ASSIGNED C.N.A **ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:** DAILY, ON WEEKDAYS THE ADMINISTRATIVE NURSE WILL PULL THE BOWEL WARNING LIST, WILL REVIEW IT AND ENSURE THAT THE PROTOCOL IS IMPLEMENTED FOR THE RESIDENTS THAT NEEDED IT. THE NURSING COORDINATOR WILL BE THE WEEKDAY BACK UP. DURING WEEKDAYS, THE 3-11 SUPERVISOR WILL MONITIOR ON A WEEKLY BASIS FOR 8 WEEKS THEN MONTHLY FOR 12 MONTHS TO ESNURE THE BOWEL WARNING REPORT IS PULLED AND FOLLOWED UP ON. ON SATURDAY AND SUNDAYS, THE WEEKEND SUPERVISOR WILL PULL THE BOWEL WARNING LIST. FOR WEEKENDS, THE DON WILL REVIEW ON EACH MONDAY FOR 8 WEEKS THAT THE LIST WAS PULLED AND THE BOWEL PROTOCOL WAS ACTIVATED AS NECESSARY. THE WEEKEND SUPERVISOR WILL COMPLETE THE MONITORING TOOL FOR EACH WEEKEND 8 WEEKS AND THEN MONTHLY FOR 12 MONTHS. IF THE WEEKEND	

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F 309	Continued From page 3 particular Monday 06/24/13 Nurse #1 had stayed over half a shift and another nurse had come in to relieve her mid shift. In addition Nurse #3 had assisted on the hall due to a new resident admission. Interview on 07/19/13 at 9:45 AM with Nurse #3 confirmed she had helped on the hall that Monday, 06/24/13, and even though she felt the bowel warning sheet had been delivered to the hall nurse the resident did not have the bowel protocol initiated. Nurse #3 revealed when she came in each day she pulled up the report to see if the resident had a bowel movement (BM). Nurse #3 noted, I checked near the end of the shift to give time for the resident to have a BM, by Tuesday, 06/25/13, 2nd shift, Resident #77 had a BM on her own. Nurse #3 confirmed on reviewing Resident #77's medical record that there had been 4 episodes to date of constipation since admission where the bowel protocol had been needed indicating a need for close monitoring. Interview on 07/19/13 at 10:00 AM with the Director of Nurses (DON) revealed she expected nursing staff to follow the established bowel protocol for all residents. The DON confirmed she had additional procedures to put into place so no warnings would be missed.	F 309	SUPERVISOR IS NOT AVAILABLE TO PULL THE BOWEL WARNING LIST ON ANY WEEKEND DAY, THE DON WILL BE RESPONSIBLE FOR DOING SO. INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: ONCE A WEEK FOR 8 WEEKS AND THEN MONTHLY, THE 3-11 NURSE SUPERVISOR AND WEEKEND SUPERVISOR WILL COMPLETE A BOWEL PROTOCOL Q.A AS THE MONITORING TOOL. THE DIRECTOR OF NURSING OR NURSING DESIGNEE WILL VISUALLY MONITOR THE Q.A RESULTS WEEKLY FOR 8 WEEKS AND THEN MONTHLY TO EVALUATE EFFECTIVENESS AND WILL MAKE CHANGES OR TAKE ACTION AS DETERMINED NECESSARY TO ENSURE CORRECTION IS ACHIEVED AND SUSTAINED.	
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	F 456	Q.A.RESULTS WILL BE REPORTED TO THE DIRECTOR OF NURSING ON A WEEKLY BASIS AND SHE WILL TAKE APPROPRIATE ACTION BASED UPON THE Q.A. RESULTS SUCH AS DETERMINING THE NEED FOR INSERVICING, DISCIPLINARY ACTION OR A CHANGE IN THE SYSTEM. THE DON WILL THEN REPORT TO THE Q.A. COMMITTEE ON A MONTHLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED SUCH AS INSERVICING OR	

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F 456	Continued From page 4 by: Based on observation and staff interview, the facility failed to make repairs, over an extended period of time, to maintain the kitchen pipes in safe, operating condition. The findings included: During an initial tour of the kitchen conducted on 07/16/13 at 7:55 AM observation was made of water overflowing onto the floor from cracked pipes under the sink next to the dish machine past the drain and out onto the floor of the kitchen. Interview on 07/16/13 at 7:57 AM with Dietary Aide #1 (DA #1), who was washing the dishes, confirmed the water was not suppose to go out onto the floor. DA #1 also revealed the pipe under the dish machine would overflow and this had been going on for 2-3 months. DA #1 further revealed the water overflow problem and cracked pipe had been reported several times to the Maintenance Director and although he had repaired it– it would crack again as the pressure from the dish machine built up. Interview on 07/16/13 at 8:00 AM with DA #2 confirmed the water goes in the floor from under the sink near the dish machine and the overflow pipe had been going off and on for 2-3 months. Observation was made on 07/16/13 at 8:07 AM of the Maintenance Director arriving in the kitchen and working with the overflowing pipes under the sink next to the dish machine. Interview with the Maintenance Director on 07/16/13 at 8:10 AM confirmed he had come into	F 456	• F456: ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ALEXANDRIA PLACE MAINTAINS ALL ESSENTIAL MECHANICAL, ELECTRICAL, AND PATIENT CARE EQUIPMENT IN SAFE OPERATING CONDITION. THE IDENTIFIED PIPE WAS NOT CRACKED. NONE OF THE PIPES ARE CRACKED. THE IDENTIFIED PIPE WAS PURPOSELY CUT AT AN ANGLE AS AN EFFORT TO RESOLVE THE DRAINING ISSUE. THE FACILITY WAS TRYING TO COMPLY WITH THE REQUIREMENTS FOR THE DRAIN PER GASTON COUNTY HEALTH DEPARTMENT AND THE CITY OF GASTONIA WHICH IS NAMED TWO RIVERS. THE MAINENANCE SUPERVISOR WAS WORKING WITH GASTON COUNTY HEALTH DEPARTMENT PRIOR TO THE SURVEY TO AFFECT A RESOLUTION TO THE PROBLEM. ON 7/15/13 THE LNHA CONTACTED THE CITY FOR ASSISTANCE FOR A DIFFERENT RESOLUTION AS THE ACTION TAKEN BY THE MAINTENANCE SUPERVISOR, PER COUNTY REQUEST WAS NOT WORKING. THE FACILITY HAD ALSO DIRECTED STAFF TO BETTER SCRAPE THE POTS AND PANS TO DECREASE THE AMOUNT OF FOOD THAT WOULD GO DOWN THE DRAIN. ON 7/16/13 THE CITY CAME TO THE FACILITY AND GAVE PERMISSION FOR THE FACILITY TO REMOVE THE GRATE OVER THE DRAIN WHICH ALLOWED THE WATER TO FLOW IN THE DRAIN FREELY. NONE OF THE RESIDENTS WERE AFFECTED BY THIS AS RESIDENTS DO NOT HAVE ACCESS TO THIS PART OF THE FACILITY.	8-12-13

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F 456	Continued From page 5 the kitchen to see about the water pouring onto the floor. He revealed the pipes had just been repaired and inspected without problems but he confirmed it was not working again and he began to work on it. On 07/16/13 at 8:13 AM observation was made in the kitchen of the 3 compartment sink. When DA #3 finished washing dishes and pulled the plug the water overflowed out onto the floor. Observation was made looking under the sink that two pieces of pipe were sitting to the side of the big pipe so the water was not directed down the drain but flowed out onto the kitchen floor. On 07/16/13 at 8:15 AM interview with DA #3 confirmed this was not supposed to happen but had happened several times over the last 2-3 months. DA #3 revealed the kitchen pipes were all connected and when the pressure built up the two pieces laying under the sink would "pop-off" and the water would flow out onto the floor. On 07/16/13 at 8:18 AM interview with the Maintenance Director, still present in the kitchen, confirmed water was coming out onto the floor from under the 3 compartment sink. He was observed to reach under the sink and reconnect the 2 removed pipe pieces to the main pipe so the water flowed back into the drain. He said staff would take those pieces off when it got stopped up and he usually came and put them back on. On 07/16/13 at 12:01 PM interview with the Dietary Manager confirmed there was an ongoing problem with pipes in the kitchen overflowing water onto the floor. The DM went on to reveal she thought it was a combination of the garbage	F 456	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: NO RESIDENT EVER HAD THE POTENTIAL TO BE AFFECTED AS THEY DO NOT HAVE ACCESS TO THIS PART OF THE FACILITY. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: ALL OF THE DRAINS WERE ASSESSED BY MAINTENANCE AND ONLY ONE OTHER DRAIN WAS SLOW TO DRAIN DUE TO THE GRATE. THE GRATES WERE REMOVED ON TWO OF THE DRAIN SINKS IN THE FLOOR. THERE ARE NOT ANY OTHER SYSTEMIC CHANGES THAT NEED TO BE MADE. CERTIFIED DIETARY MANAGER OR DIETARY CONSULTANT TO COMPLETE AN AUDIT/Q.A. TOOL WEEKLY FOR 8 WEEKS THEN MONTHLY FOR 12 WEEKS BY CHECKING THE DRAINS TO ENSURE THEY NOT CLOGGED, ARE DRAINING PROPERLY AND NO WATER FROM THE DRAINS IS ON THE FLOOR, TO ENSURE THAT THE GRATE REMOVAL WAS EFFECTIVE. IF IT IS DETERMINED THAT THE GRATE REMOVAL WAS NOT EFFECTIVE THEN MAINTENANCE WILL BE NOTIFIED SO THEY CAN CHECK THE DRAIN AND TAKE ACTION BASED ON THEIR ASSESSMENT.	

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F 456	Continued From page 6 disposal system and dish washer releasing at the same time and the water pressure was too much for the pipes and the pipes would kick loose and let water flow out onto the floor. The DM revealed she had spoken with the Administrator to let her know the problem was not remaining fixed but recurring. On 07/16/13 at 12:10 PM interview with Dietary Service Consultant (DSC) revealed she was aware of the water situation that had been ongoing for the last 2-3 months. The DSC further revealed to her knowledge the pipe lines would become stopped up, pressure would build up as the dish washer and garbage disposal used the same pipe lines and then water would be out on the floor under the dish machine. Under the 3 compartment sink she had been told by the Maintenance Director that the trap was not big enough and food particle, salt packets and debris from the sink would be caught and stop it up and then back up would occur and overflow coming out into the kitchen. The DSC confirmed a permanent solution was needed. On 07/16/13 at 12:15 PM interview with the Registered Dietitian confirmed she was aware of the ongoing problem and provided a report that documented she had noted it as a recommendation on 06/18/13 in her report to the facility. On 07/16/13 at 12:20 PM interview with the DM revealed the two pipes under the 3 compartment sink popped off when it got stopped up by debris. The DM confirmed she verbally told the Administrator and the Maintenance Director a permanent solution was needed, but did not document a request.	F 456	INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY.: ON A WEEKLY BASIS FOR 8 WEEKS THEN MONTHLY FOR 12 MONTHS THE DIETARY MANAGER OR DIETARY CONSULTANT WILL MONITOR THE DRAINS BY USING THE Q.A TOOL. IF THERE ARE ANY ISSUES THE DIETARY MANAGER WILL REPORT THEM TO MAINTENANCE TO REPAIR OR DETERMINE IF THE CITY NEEDS TO RETURN OR IF OTHER OUTSIDE CONTRACTORS NEED TO BE CALLED IN. MONITORING / AUDITING / Q.A. RESULTS WILL BE REPORTED TO THE Q.A. COMMITTEE ON A MONTHLY BASIS FOR REVIEW AND DETERMINATION IF FURTHER OR AMENDED ACTION IS REQUIRED ABOVE AND BEYOND OTHER ACTION THAT MAY HAVE ALREADY BEEN TAKEN. THE Q.A. COMMITTEE WILL BE CHARGED WITH THE RESPONSIBILITY TO ENSURE THAT CORRECTION IS ACHIEVED AND SUSTAINED.	

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F 456	Continued From page 7 On 07/16/13 at 2:40 PM interview with the Administrator revealed the Maintenance Director changed the kitchen pipes the end of February, 2013 at the advisement of the city inspector. The Administrator provided the document for review that showed the kitchen inspection was 3/20/13 and passed. The Administrator then noted it took a while for the food to back up with the new suggested system and then the 3 compartment sink would overflow. The Administrator confirmed the suggested system had not worked and she had just contacted him yesterday, 07/15/13, for additional assistance.	F 456		