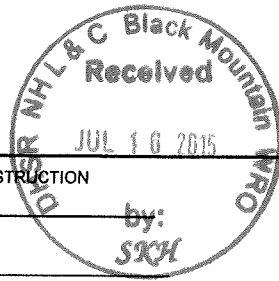


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTERSVILLE OAKS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078</b>	
(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 157 SS=G	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, nurse practitioner and physician interviews the facility failed to notify the physician of a resident with difficulty breathing</p>	F 157	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>Resident #3 was transferred to the hospital for an evaluation and did not return to the facility. Nurse #1 was counseled for failing to meet professional standards of practice.</p> <p>Director of Nursing conducted an audit of all residents with orders for Coumadin and determined the orders and validating Medication Administration Record documentation was in compliance.</p> <p>Nurses will be provided education by the Director of Clinical Operations and Outcomes, regarding Provider Call Guidelines, lab protocol, utilizing PT/INR machine, evaluation and ongoing monitoring of a resident. Nursing staff will not be allowed to work a scheduled shift until they have reviewed and signed that education has been completed.</p> <p>Director of Nursing or designee will audit 100% of residents with orders for PT/INR, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.</p>	7/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Scharae L. Majrad*

*Administrator*

*7-15-15*

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.

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F 157	Continued From page 1 and the inability to collect an ordered laboratory test for 1 of 3 residents reviewed for notification of change (Resident #3). The findings included: Resident #3 was admitted to the facility on 03/20/15 with diagnoses of rib fractures, atrial fibrillation and hypertension. A review of the Nursing Admission Cognitive Status revealed Resident #3 was alert and oriented to person, place and time. A review of physician's orders dated 04/02/15 revealed in part: Coumadin, a blood thinner, 3 milligrams (mg) by mouth once a day for atrial fibrillation. Lovenox, a blood thinner, 80 milligrams by injection every 12 hours for atrial fibrillation. The nurse's note dated 04/03/15 at 2:30 AM revealed a late entry for 04/02/15. The note indicated Resident #3 had a "black" bowel movement at 7:00 PM and a second positive hemocult was collected and the physician was notified. The new orders were for vital signs to be obtained every hour, a complete blood count (a blood test) to be drawn immediately, a prothrombin time (PT)/international normalized ratio (INR), (a test to monitor the effectiveness of the blood thinner to assure it is at a therapeutic level without causing excessive bleeding), to be done immediately, and withhold Resident #3's blood pressure medication. The note revealed the PT/INR was attempted 6 times and each time an error message was received with the last message stating the blood was too thin to read. The note further indicated at 1:30 AM Resident #3 had a third positive hemocult test with the stool being a "black pudding consistency" and Resident #3 had complained of difficulty breathing at the 1:30 AM vital sign check. The note revealed Resident #3 had 15 plus bruises on	F 157			

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F 157	<p>Continued From page 2</p> <p>her arms and legs and no other complaints of difficulty breathing at that time. There was no indication from the nurse's note that the physician was notified of the nurse not being able to collect the PT/INR or Resident #3's difficulty breathing at 1:30 AM on 04/03/15.</p> <p>Review of the nurse's note dated 04/03/15 at 10:20 AM revealed Resident #3 was diaphoretic, finger tips were blue and she was very pale with vital signs of oxygen saturation 92%, respirations 24, pulse 67, fasting blood sugar 100 and blood pressure 119/70. The note stated Resident #3's oxygen saturation dropped to 67% and oxygen was increased to 3 liters per minute via nasal cannula with the oxygen saturation not coming up. The note further revealed a call was placed to the Nurse Practitioner with an order received to send Resident #3 to the hospital for evaluation. Review of the hourly vital signs for Resident #3 on 04/02/15 through 04/03/15 from 7:30 PM to 8:30 AM revealed the vital signs to be within normal limits with no major fluctuations. There were no vital sign checks between 8:30 AM and 10:20 AM.</p> <p>A review of the hospital emergency department report dated 04/03/15 at 2:36 PM indicated Resident #3 was admitted with a gastrointestinal hemorrhage (bleeding) and anemia (a decrease in the amount of red blood cells) secondary to the hemorrhage. The records indicated Resident #3 received a unit of blood during transport to the hospital and another unit of blood upon arrival to the hospital with a hemoglobin, (a protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the body's tissues back to the lungs), of 6.1 with the normal hemoglobin range being 11.5 to 15.0. Resident #3 was discharged from the hospital in stable condition</p>	F 157		
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F 157	<p>Continued From page 3 on 04/16/15.</p> <p>During an interview conducted on 06/18/15 at 3:35 PM with Nurse #1 she confirmed she provided care to Resident #3 during the 7:00 PM to 7:00 AM shift of 04/02/15 through 04/03/15. She stated the nurse aide (NA) asked her to look at Resident #3's stool because it was very black. Nurse #1 stated she followed the facility Standing Orders and collected a hemocult which was positive Nurse #3 that was going off duty called the Nurse Practitioner with the positive results and received orders for vital sign checks every hour, a stat CBC and PT/INR and to hold the blood pressure medication. She stated she attempted to collect the PT/INR 6 times and each time the machine gave her an error message with the last message stating the blood was too thin to read, she reported she did not notify the physician or the Nurse Practitioner she was unable to collect the PT/INR. Nurse #1 stated she started vital sign checks at 7:30 PM. She explained that Resident #3 complained of difficulty breathing at the 1:30 AM vital sign check and had not had any prior complaints of difficulty breathing and she assumed it was from her cracked ribs. She reported she asked Resident #3 if the difficulty breathing was from her cracked ribs and Resident #3 stated it might be. She stated she did not notify the physician of Resident #3's complaint of difficulty breathing at 1:30 AM and did not provide Resident #3 with any interventions to relieve difficulty breathing.</p> <p>During an interview on 06/18/15 at 3:46 PM with Nurse #2 she confirmed she was assigned to care for Resident #3 on 04/03/15 during the 7:00 AM to 3:00 PM shift. She stated she was not informed during the shift report Resident #3 had 2 positive hemocults, difficulty breathing during the night and vital signs ordered every hour and she</p>	F 157		
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F 157	<p>Continued From page 4</p> <p>did not see the new order for hourly vital sign checks. Nurse #2 stated she looked in on Resident #3 from the hallway at the beginning of her shift and when she went in to see her at approximately 10:00 AM she was diaphoretic, her finger tips were blue and she was very pale. Nurse #2 stated she assessed Resident #3's vital signs and checked her oxygen saturation due to her finger tips being blue. She stated Resident #3 was receiving 2 liters of oxygen via nasal cannula per physician orders and her oxygen saturation dropped to 67% even with an increase to 3 liters of oxygen via nasal cannula. Nurse #2 stated the Nurse Leader called the Nurse Practitioner and received an order to send Resident #3 to the hospital for evaluation.</p> <p>The nurse aide that worked with Resident #3 on the 7:00 AM to 3:00 PM shift on 04/03/15 was not available for interview.</p> <p>During an interview conducted on 06/18/15 at 5:01 PM with the Nurse Practitioner (NP) she revealed it was her expectation to be notified if a resident had a change in condition or physician orders were unable to be carried out. She stated she should have been notified when Nurse #1 was unable to collect the PT/INR and when Resident #3 complained of difficulty breathing with the 1:30 AM vital sign check. The NP stated she would have sent Resident #3 out for evaluation at that time due to the possibility of a gastrointestinal (GI) bleed.</p> <p>During an interview on 06/18/15 at 5:05 PM with the Director of Nursing (DON) she confirmed it was her expectation if an order was received to collect a stat PT/INR and the nurse was unable to obtain the PT/INR the Physician should have been notified. The DON stated vital signs should have been checked every hour until the Physician discontinued the order and she could not find any</p>	F 157			

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F 157	Continued From page 5 vital sign checks from 8:30 AM until 10:20 AM on 04/03/15 for Resident #3. She further stated the nurse should have completed a Situation Background Assessment Request (SBAR) Communication Form for Resident #3 for the positive hemocults and difficulty breathing and notified the Physician and oncoming nurse. During an interview conducted on 06/19/15 at 9:07 AM with the Physician he stated he would not have been concerned if the nurse had been unable to obtain the ordered PT/INR if the resident was clinically stable but he did want to know that she was having difficulty breathing. He stated he would have sent her out for evaluation at that time due to a possible GI bleed. The Physician further stated if he ordered vital signs to be checked every hour he expected them to be checked until he discontinued the order.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct a timely investigation of a grievance for 1 of 2 residents reviewed for grievances (Resident #4). The findings included: Review of the Carolinas Healthcare System Skilled Nursing Facilities Grievance Policy with a reviewed date of 08/2014 read in part: E. If more than five (5) business days are	F 166	Resident #4's family member filed a grievance on 3/13/15. The date of resolution was 4/2/15 but the Department Head and Administrator signature was not obtained until 6/17/15. On 7/10/15, Social Worker contacted the family member to ensure Action Plan continues to resolve the issues.  Facility staff will be provided education by the Director of Clinical Operations and Outcomes, regarding Grievance Policy/Procedure and new process for transfer of information. Employees will not be allowed to work a scheduled shift until they have reviewed and signed that education has been completed.	

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F 166	<p>Continued From page 6</p> <p>required to resolve the grievance, provide a status report to the resident and/or person who voiced the grievance, within five (5) business days and communicate the resolution as soon as possible.</p> <p>Resident #4 was admitted to the facility on 08/11/12 with diagnoses of congestive heart failure, diabetes and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 03/20/15 revealed Resident #4 was severely cognitively impaired but he was understood and could understand others. The MDS further revealed Resident #4 required extensive assistance with transfers, toileting and personal hygiene.</p> <p>Review of Carolinas Healthcare System Long Term Care Grievance Form dated 03/13/15 revealed:</p> <ul style="list-style-type: none"> <li>· Statement of Concern was Resident #4's family member filed a grievance related to arriving at the facility at 8:00 PM on 03/13/15 to find Resident #4's room door shut and his wheelchair alarm going off which she could hear in the hallway. The family member was upset due to Resident #4 being on the toilet with his alarm sounding and staff had not checked on him. The grievance further indicated the family member had to go to the kitchen to find a staff member to help Resident #4 and was told they were taking a break.</li> <li>· Investigation was reviewed staffing for 03/13/15.</li> <li>· Action Plan and Nature of Resolution was coached teammates on the 3:00 PM to 11:00 PM shift and reminded them to round frequently.</li> <li>· Date of Resolution was 04/02/15 and reviewed with family member.</li> <li>· Was it within 5 business days - no, complaint was lost initially, found 03/26/15.</li> </ul>	F 166	<p>The Grievance form will be in a duplicate format with the original submitted to the Administrator and the duplicate to the Department Manager. The Administrator will discuss with the administrative team during Stand Up and submit to the Social Worker to be logged and assist with the investigation.</p> <p>Administrator or designee will audit grievance log weekly, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.</p>	7/17/2015	

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F 166	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>· Completed by Nurse Mentor on Garden Terrace on 04/02/15</li> <li>· Department Head Signature - Director of Nursing (DON) on 06/17/15</li> <li>· Administrator signature on 06/17/15</li> </ul> <p>During an interview conducted on 06/19/15 at 10:20 AM with the Nurse Mentor #1 she explained she received grievances for the Garden Terrace neighborhood. She stated the facility policy was for grievances to be resolved within 5 days and if they weren't you were to meet or call the person that filed the grievance to explain why they were not resolved. She stated she was on medical leave when Resident #4's grievance was filed and when she returned to work on 04/02/15 she found the grievance on her desk. She stated Nurse Mentor #2 filled in for her while she was on medical leave and should have reviewed the grievance when it was received. Nurse Mentor #1 stated she immediately reviewed the grievance and spoke with Resident #4's family member that filed the grievance.</p> <p>Nurse Mentor #2 was unavailable for interview. During an interview conducted on 06/19/15 at 4:31 PM with the Administrator she stated grievances should be resolved within 5 days per facility policy. She stated if the grievance could not be resolved within 5 days the person that filed the grievance should have been contacted and given a reason the grievance had not been resolved. She stated the Grievance filed for Resident #4 on 03/13/15 should have been reviewed by the nurse mentor covering for Nurse Mentor #1 while she was on medical leave. She further stated she was aware there were problems with the grievance procedure and was in the process of reviewing the procedure.</p>	F 166		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		



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F 242 SS=D	<p>Continued From page 8 <b>MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide showers per resident choice for 1 of 3 residents reviewed for choices (Resident #6). The findings included: Resident #6 was admitted to the facility on 04/08/13 with diagnoses of neurogenic bladder, diabetes and Multiple Sclerosis (MS). The quarterly Minimum Data Set (MDS) dated 02/04/15 revealed Resident #6 was cognitively intact and was dependent for transfers and bathing. Review of Resident #6's care plan dated 05/13/15 revealed Resident #6 needed assistance for most activities of daily living (ADL) due to paraplegia, MS and limited mobility. The goal was for Resident #6 to continue to participate as able with ADL to the next review period. Interventions included set up for daily bathing, grooming, and dressing and encourage to do as much for self as able, assist to complete. Resident #6 to get 2 showers per week per residents request. Review of the facility ADL Detail Report from 05/11/15 through 06/19/15 revealed Resident #6 had 8 showers. An interview was conducted on 06/18/15 at 11:00</p>	F 242	<p>Director of Nursing met with Resident #6, to assess shower frequency preference. Shower schedule was updated based on resident's preference.</p> <p>Facility wide audit was conducted with residents and/or Responsible Party to evaluate shower/bath frequency preferences. Shower/bath schedules were updated in accordance with each resident's frequency preference.</p> <p>The Admission Packet was updated to include information regarding shower/bath frequency, based on resident's preference.</p> <p>Director of Nursing or designee will conduct weekly (10%) audits of residents to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.</p>	7/17/2015	

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F 242	<p>Continued From page 9</p> <p>AM with nurse aide (NA) #1. She stated she provided care for Resident #6 and she wasn't always able to give showers as ordered for Resident #6 due to being short staffed. NA #1 stated if they had 3 NAs on the 7:00 AM to 3:00 PM shift she was able to complete all ordered showers but if there were only 2 NAs working some showers didn't get done.</p> <p>During an interview on 06/19/15 at 1:06 PM with Resident #6 she stated it was very important to her to have 2 showers a week. She stated the staff are so busy or short staffed that they miss her showers and she does not get them as scheduled. Resident #6 stated she has spoken to the Director of Nursing (DON) and the Administrator about missing showers but she still continued to miss showers.</p> <p>An interview was conducted on 06/19/15 at 1:50 PM with NA #2. She stated she provided care to Resident #6 on the 7:00 AM to 3:00 PM shift and stated if there are only 2 NAs on the hall she did not get all of the scheduled showers done.</p> <p>During an interview on 06/19/15 at 4:15 PM with the DON she explained she had spoken to Resident #6 about not receiving her showers as ordered and had also spoken to staff about making sure Resident #6 received 2 showers per week. The DON stated it was her expectation that showers be given as ordered and if they were missed it should be reported to the oncoming shift to give the shower. She further stated she was aware of resident and family complaints that the halls were short staffed and showers were not being done.</p> <p>An interview with the Administrator on 06/19/15 at 4:31 PM revealed she expected residents to receive their showers as scheduled and also expected the NAs to inform the nurse if they were not able to complete an assigned shower during</p>	F 242		
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F 242	Continued From page 10 their shift.	F 242			
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:            Identification and demographic information;            Customary routine;            Cognitive patterns;            Communication;            Vision;            Mood and behavior patterns;            Psychosocial well-being;            Physical functioning and structural problems;            Continence;            Disease diagnosis and health conditions;            Dental and nutritional status;            Skin conditions;            Activity pursuit;            Medications;            Special treatments and procedures;            Discharge potential;            Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and            Documentation of participation in assessment.</p>	F 272	<p>Resident #1 Care Area Assessment in the areas of ADL, Pressure Ulcer, and Positioning was reviewed and analyzed by the MDS Coordinator to ensure there was a comprehensive assessment which included an analysis identifying how the conditions affected the resident's function and quality of life.</p> <p>Resident #2 Care Area Assessment in the areas of Cognitive Loss/Dementia and ADL was reviewed and analyzed by the Social Worker and MDS Coordinator to ensure there was a comprehensive assessment which included an analysis identifying how the conditions affected the resident's function and quality of life.</p> <p>MDS Coordinators and Social Worker will be provided education by the Director of Clinical Operations and Outcomes, regarding Federal and State regulation on completing a comprehensive assessment which included an analysis identifying how the conditions affected the resident's function and quality of life.</p> <p>MDS Coordinators will review Care Area Assessments for all newly completed comprehensive assessments for July and forward to ensure there was a comprehensive assessment which included an analysis identifying how the conditions affected the resident's function and quality of life.</p>		

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F 272	Continued From page 11  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to comprehensively assess 2 of 2 sampled residents identifying how their condition affected each resident's function and quality of life (Residents #1 and #2).  The findings included:  1) Resident #1 was admitted to the facility on 08/15/14 with diagnoses which included dementia, cerebral vascular accident (stroke), and diabetes mellitus.  A review of the admission Minimum Data Set (MDS) dated 08/25/14 indicated Resident #1 was severely impaired in cognition for daily decision making (scoring a 0 out of 15 on the brief interview for mental status). The MDS also indicated Resident #1 required extensive physical assistance of 1 person for activities of daily living (ADLs) which included dressing, eating, toileting, and personal hygiene, and was totally dependent on staff for bathing, and was always incontinent of bowel and bladder, and had no documented behaviors or refusal of care.  Review of the Care Area Assessments (CAA) dated 09/10/14 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses, and how her condition affected those areas: a) ADL CAA: revealed there was no documentation and/or analysis related to if any of	F 272	Director of Nursing or designee, will conduct weekly (10%) audits of the Care Area Assessments to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	7/17/2015	

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F 272	<p>Continued From page 12</p> <p>her ADLs could improve or how they affected her function and quality of life.</p> <p>b) Pressure Ulcer CAA: triggered condition due to the developing of pressure ulcers as indicated as stage 3 or greater. Further review of the CAA revealed there was no documentation and/or analysis of causes and contributing factors to determine reason for the increased number of pressure ulcers and no documentation specific to Resident #1. The CAA did not indicate an analysis of how her every day quality of life was impacted or affected.</p> <p>c) Positioning CAA: revealed there was no documentation and/or analysis related to turning and positioning could have improved the multiple pressure ulcers or any analysis of how her every day quality of life was impacted or affected.</p> <p>Interview with the MDS Coordinator on 06/19/15 at 10:45 AM revealed she completed all the MDSs and CAAs in the building. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. The MDS Coordinator explained she had been doing MDSs and CAAs for approximately 9 plus years and verified the CAA did not contain documentation of analysis of findings specific to Resident #1 and/or the decision to proceed to care plan other than the resident's diagnoses. She further reported a comprehensive assessment of Resident #1's ADLs, positioning, and pressure ulcers was not conducted and she could not provide a reason for the error on the MDS except for that was the way she was trained.</p>	F 272		
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F 272	<p>Continued From page 13</p> <p>2) Resident #2 was admitted to the facility on 01/24/15 with diagnoses which included diabetes mellitus, coronary vessel disease, blindness, and cerebral vascular accident (stroke).</p> <p>A review of the most recent Minimum Data Set (MDS) dated 02/12/15 indicated Resident #2 was cognitively impaired, requiring total physical assistance of 2 persons for bed mobility, transfers, and bathing, and extensive physical assistance of 1 person assist with dressing, eating, toileting, and personal hygiene. Further review of the MDS coded Resident #2 as being non-ambulatory, always incontinent of bowel and bladder, and receiving antianxiety medications 7 out of 7 days.</p> <p>Review of the Care Area Assessment (CAA) dated 02/23/15 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses, and how her condition affected these areas:</p> <p>a) Cognitive Loss/Dementia CAA: revealed there was no documentation and/or analysis related to if any of her cognitive loss could improve or how her cognition affected her function and quality of life.</p> <p>b) ADL CAA: revealed there was no documentation and/or analysis related to if any of her ADLs could improve or how they affected her function and quality of life.</p> <p>Interview with the MDS Coordinator on 06/19/15 at 10:45 AM revealed she completed all the MDSs and CAAs in the building. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the</p>	F 272			

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F 272	Continued From page 14 documentation in the medical record. The MDS Coordinator explained she had been doing MDSs and CAAs for approximately 9 plus years and verified the CAA did not contain documentation of analysis of findings specific to Resident #2 and/or the decision to proceed to care plan other than the resident's diagnoses. She further reported a comprehensive assessment of Resident #2's cognitive loss and ADLs was not conducted and she could not provide a reason for the error on the MDS except for that was the way she was trained.	F 272			
F 309 SS=G	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 reviews, staff, nurse practitioner and physician interviews the facility failed to report a resident change in condition to the oncoming shift; failed to provide ongoing assessment of a resident with difficulty breathing and failed to obtain a physician ordered laboratory test 1 of 3 sampled residents with a change in condition (Resident #3). The findings included: Resident #3 was admitted to the facility on 03/20/15 with diagnoses of rib fractures, atrial fibrillation and hypertension. A review of the	F 309	Resident #3 was transferred to the hospital for an evaluation and did not return to the facility. Nurse #1 was counseled for failing to meet professional standards of practice.  Director of Nursing conducted an audit of all residents with orders for Coumadin and determined the orders and validating Medication Administration Record documentation was in compliance.  Nurses will be provided education by the Director of Clinical Operations and Outcomes, regarding Provider Call Guidelines, lab protocol, utilizing PT/INR machine, evaluation and ongoing monitoring of a resident, and expectations for nurse to nurse handoff communication. Nursing staff will not be allowed to work a scheduled shift until they have reviewed and signed that education has been completed.  Director of Nursing or designee will audit 100% of residents with orders for PT/INR, to ensure compliance.		

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F 309	<p>Continued From page 15</p> <p>Nursing Admission Cognitive Status revealed Resident #3 was alert and oriented to person, place and time. The Minimum Data Set (MDS) had not been completed for Resident #3.</p> <p>Review of Resident #3's care plan dated 03/23/15 revealed she had the potential for medication side effects related to the use of blood thinners. The goal was for Resident #3 to have no side effects from the medications that resulted in injury for the next 2 weeks. Interventions included monitor for side effects as related to the medication, monitor for changes in behavior, monitor labs as ordered, monitor for change in mental status, consult Physician as needed and pharmacy to review drug regime monthly.</p> <p>A review of physician's orders dated 04/02/15 revealed in part:</p> <p>Coumadin, (a blood thinner), 3 milligrams (mg) by mouth once a day for atrial fibrillation.</p> <p>Lovenox, (a blood thinner), 80mg by injection every 12 hours for atrial fibrillation.</p> <p>Review of the facility Physician Standing Orders for suspected bloody stools or emesis stated to collect a hemocult and notify the Provider if positive.</p> <p>Review of the nurse's note dated 04/02/15 at 6:00 PM revealed Resident #3 had a dark chocolate colored stool and a hemocult (a test for presence of blood in stool) was collected and was positive. The note indicated the physician was notified and new orders were received.</p> <p>The nurse's note dated 04/03/15 at 2:30 AM revealed a late entry for 04/02/15. The note indicated Resident #3 had a "black" bowel movement at 7:00 PM and a second positive hemocult was collected and the physician was notified. The new orders were for vital signs to be obtained every hour, a complete blood count (a blood test) to be drawn immediately, a</p>	F 309	<p>In addition, Director of Nursing or designee, will conduct weekly observations of 10% of nurses performing nurse to nurse hand off, to ensure compliance. Any identified issues will be corrected at that time.</p> <p>Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.</p>	7/17/2015



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F 309	<p>Continued From page 16</p> <p>prothrombin time (PT)/international normalized ratio (INR), (a test to monitor the effectiveness of the blood thinner to assure it is at a therapeutic level without causing excessive bleeding), to be done immediately, and withhold Resident #3's blood pressure medication. The note revealed the PT/INR was attempted 6 times and each time an error message was received with the last message stating the blood was too thin to read. The note further indicated at 1:30 AM Resident #3 had a third positive hemocult test with the stool being a " black pudding consistency " and Resident #3 had complained of difficulty breathing at the 1:30 AM vital sign check. The note revealed Resident #3 had 15 plus bruises on her arms and legs and no other complaints of difficulty breathing at that time. There was no indication from the nurse's note that the physician was notified of the nurse not being able to collect the PT/INR or Resident #3's difficulty breathing at 1:30 AM on 04/03/15.</p> <p>Review of the nurse's note dated 04/03/15 at 10:20 AM revealed Resident #3 was diaphoretic, finger tips were blue and she was very pale with vital signs of oxygen saturation 92%, respirations 24, pulse 67, fasting blood sugar 100 and blood pressure 119/70. The note stated Resident #3 ' s oxygen saturation dropped to 67% and oxygen was increased to 3 liters per minute via nasal cannula with the oxygen saturation not coming up. The note further revealed a call was placed to the Nurse Practitioner with an order received to send Resident #3 to the hospital for evaluation. Review of the hourly vital signs for Resident #3 on 04/02/15 through 04/03/15 from 7:30 PM to 8:30 AM revealed the vital signs to be within normal limits with no major fluctuations. There were no vital sign checks between 8:30 AM and 10:20 AM.</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>A review of the hospital emergency department report dated 04/03/15 at 2:36 PM indicated Resident #3 was admitted with a gastrointestinal hemorrhage (bleeding) and anemia (a decrease in the amount of red blood cells) secondary to the hemorrhage. The records indicated Resident #3 received a unit of blood during transport to the hospital and another unit of blood upon arrival to the hospital with a hemoglobin, (a protein molecule in red blood cells that carries oxygen from the lungs to the body ' s tissues and returns carbon dioxide from the body's tissues back to the lungs), of 6.1 with the normal hemoglobin range being 11.5 to 15.0. Resident #3 was discharged from the hospital in stable condition on 04/16/15.</p> <p>During an interview conducted on 06/18/15 at 3:35 PM with Nurse #1 she confirmed she provided care to Resident #3 during the 7:00 PM to 7:00 AM shift of 04/02/15 through 04/03/15. She stated the nurse aide (NA) asked her to look at Resident #3's stool because it was very black. Nurse #1 stated she followed the facility Standing Orders and collected a hemocult which was positive Nurse #3 that was going off duty called the Nurse Practitioner with the positive results and received orders for vital sign checks every hour, a stat CBC and PT/INR and to hold the blood pressure medication. She stated she attempted to collect the PT/INR 6 times and each time the machine gave her an error message with the last message stating the blood was too thin to read, she reported she did not notify the physician she was unable to collect the PT/INR. Nurse #1 stated she started vital sign checks at 7:30 PM. She explained that Resident #3 complained of difficulty breathing at the 1:30 AM vital sign check and had not had any prior complaints of difficulty breathing and she assumed it was from her</p>	F 309		
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F 309	Continued From page 18 cracked ribs. She reported she asked Resident #3 if the difficulty breathing was from her cracked ribs and Resident #3 stated it might be. She stated she did not notify the physician of Resident #3's complaint of difficulty breathing at 1:30 AM and did not provide Resident #3 with any interventions to relieve difficulty breathing. During an interview on 06/18/15 at 3:46 PM with Nurse #2 she confirmed she was assigned to care for Resident #3 on 04/03/15 during the 7:00 AM to 3:00 PM shift. She stated she was not informed during the shift report Resident #3 had 3 positive hemocults, difficulty breathing during the night and vital signs ordered every hour and she did not see the new order for hourly vital sign checks. Nurse #2 stated she looked in on Resident #3 from the hallway at the beginning of her shift and when she went in to see her at approximately 10:00 AM she was diaphoretic, her finger tips were blue and she was very pale. Nurse #2 stated she assessed Resident #3's vital signs and checked her oxygen saturation due to her finger tips being blue. She stated Resident #3 was receiving 2 liters of oxygen via nasal cannula per physician orders and her oxygen saturation dropped to 67% even with an increase to 3 liters of oxygen via nasal cannula. Nurse #2 stated the Nurse Leader called the Nurse Practitioner and received an order to send Resident #3 to the hospital for evaluation. The nurse aide that worked with Resident #3 on the 7:00 AM to 3:00 PM shift on 04/03/15 was not available for interview. During an interview conducted on 06/18/15 at 5:01 PM with the Nurse Practitioner (NP) she revealed it was her expectation to be notified if a resident had a change in condition or physician orders were unable to be carried out. She stated she should have been notified when Nurse #1	F 309			

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F 309	Continued From page 19 was unable to collect the PT/INR and when Resident #3 complained of difficulty breathing with the 1:30 AM vital sign check. The NP stated she would have sent Resident #3 out for evaluation at that time due to the possibility of a gastrointestinal (GI) bleed. During an interview on 06/18/15 at 5:05 PM with the Director of Nursing (DON) she confirmed it was her expectation if an order was received to collect a stat PT/INR and the nurse was unable to obtain the PT/INR the Physician should have been notified. The DON stated vital signs should have been checked every hour until the Physician discontinued the order and she could not find any vital sign checks from 8:30 AM until 10:20 AM on 04/03/15 for Resident #3. She further stated the nurse should have completed a SBAR Communication Form for Resident #3 for the positive hemocults and difficulty breathing and notified the Physician and oncoming nurse. During an interview conducted on 06/19/15 at 9:07 AM with the Physician he stated he would not have been concerned if the nurse had been unable to obtain the ordered PT/INR if the resident was clinically stable but he did want to know that she was having difficulty breathing. He stated he would have sent her out for evaluation at that time due to a possible GI bleed. The Physician further stated if he ordered vital signs to be checked every hour he expected them to be checked until he discontinued the order.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	Resident #1 was reassessed by the Interdisciplinary Care Team to ensure interventions were in place to address resident's need for staff assistance with incontinence, due to self-care deficits.	

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F 312	Continued From page 20  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, and staff interviews the facility failed to provide incontinence care to a resident who required assistance with activities of daily living for 1 of 4 sampled residents dependent on staff for activities of daily living (Resident #1).  The findings included:  Resident #1 was admitted to the facility on 08/15/14 with diagnoses which included dementia and cerebral vascular accident (stroke). Review of the Minimum Data Set (MDS) dated 02/26/15 indicated Resident #1 had severe cognitive impairment, was unable to be understood, and was incapable of making her needs known. Resident #1 required extensive assistance with 1 person physical assist for activities of daily living (ADLs) which included dressing, eating, toileting, and personal hygiene, and was totally dependent on staff for bathing, and was always incontinent of bowel and bladder, and had no documented behaviors or refusal of care.  A review of care plans dated 05/20/15 revealed Resident #1 required assistance with ADLs due to self-care impairment with approaches for staff to assist with ADLs.  During an interview on 06/17/15 at 12:03 PM Resident #1's family member stated she visited the facility every day to feed Resident #1 her breakfast and lunch meals and had observed the resident lying in wet briefs at least 3 to 4 times out	F 312	Nursing staff will be provided education by member of Nursing Leadership regarding Pericare including demonstrations, emphasis on providing appropriate incontinence care during turning and repositioning, and policy/procedure review.  A member of Nursing Leadership will conduct weekly observations of 10% of Nurse Aides performing incontinence care, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	7/17/2015
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F 312	<p>Continued From page 21</p> <p>of the 7 days she visited. The family member indicated during her visits with Resident #1 the staff was much less attentive and would rarely check on the resident unless the family member asked the staff for assistance with Resident #1.</p> <p>On 06/17/15 at 2:48 PM Nurse Aide (NA) #1 was observed to provide incontinence care for Resident #1 while Nurse #3 provided the wet wash clothes. Resident #1 was observed lying on her right side while NA #1 cleaned the resident's buttock area only. NA #1 and Nurse #3 were observed to turn the resident onto her left side while Nurse #3 completed a pressure sore dressing change to Resident #1's sacral area and a dry brief.</p> <p>During an interview on 06/17/15 at 3:22 PM Nurse #3 stated it was her expectation that residents should be checked and changed every 2 hours and more often if needed. She indicated she would have expected NA #1 to have turned the resident onto her back as to ensure the resident's perineal area was cleaned first and then turned the resident onto her side and cleaned the buttock area. Nurse #3 indicated she was not paying any attention and was focused on providing enough wet washcloths for NA #1. She further stated the NAs worked hard to keep the residents clean and dry but there were times when the ADLs were not getting done and residents had to wait more than an hour.</p> <p>During an interview on 06/18/15 at 10:07 AM NA #1 stated she was expected to clean the perineal area first, turn the resident onto their side, and then clean the buttock area. She further stated she had incorrectly performed incontinence care for Resident #1 on 06/17/15 but that was the</p>	F 312		
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F 312	Continued From page 22 fastest way to get a resident clean because there were times when residents were not changed every 2 hours because there was not enough time to meet the ADLs of all the residents on the halls because the NAs were so busy.  During an interview on 06/18/15 at 12:36 PM the Director of Nursing (DON) stated it was her expectation that the NAs followed the procedures for incontinence care and that all ADL needs were provided for the resident if needed. She further stated she was unaware the residents ADLs were not being provided in a timely manner.	F 312			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interviews, the facility failed to assess a resident with a healed pressure sore which progressed to a stage 4 pressure sore and failed to conduct weekly skin assessments for 1 of 3 residents reviewed for pressure sores (Resident #1).  The findings included:	F 314	Physician assessed Resident #1's pressure sore, updated orders, and obtained a new pressure relieving mattress on 6/22/15. Resident #1's Interdisciplinary Care Team updated the resident's care plan to ensure interventions were in place to address resident's goal to prevent infection and decrease size of wound, including recommendations from the Wound Care Center.  Nurses will be provided education by the Director of Clinical Operations and Outcomes, regarding assessment of pressure sores with an emphasis on consistent evaluation skills necessary for measurement and description of wounds, expectation to conduct weekly skin assessments, and policy/procedure review. Nursing staff will not be allowed to work a scheduled shift until they have reviewed and signed that education has been completed.  Acute Interdisciplinary Team (AIT) will audit 100% of residents with pressure sores, to ensure compliance.		

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F 314	<p>Continued From page 23</p> <p>Resident #1 was admitted to the facility on 08/15/14 with diagnoses which included dementia, cerebral vascular accident (stroke), and diabetes mellitus.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated 02/26/15 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance of 1 or 2 person physical assist for activities of daily living (ADLs) and Section M of the MDS titled Skin Conditions indicated Resident #1 was at risk for developing pressure sores and having 1 stage 2 pressure sore and 1 stage 4 pressure sore.</p> <p>A review of an updated care plan with a dated 02/28/15 indicated a problem statement of at risk for skin breakdown related to limited mobility and incontinence. The goals indicated resident would remain free of skin breakdown and the approaches were listed in part to provide incontinence care as needed, provide treatments as ordered, assist with turning and repositioning as needed, weekly and as needed skin assessments, and check skin closely during bathing. The care plan further indicated Resident #1 had a pressure sore of the coccyx which had healed as of 01/13/15.</p> <p>A review of the wound physician's note dated 03/03/15 read in part stage 3 pressure sore of the coccyx resolved (healed) and to follow up as needed.</p> <p>A review of a weekly skin integrity review dated 03/14/15 indicated in a section labeled Current Skin Condition: Redness, Open Area to the sacral</p>	F 314	<p>In addition, AIT will conduct audits of 10% of facility resident's weekly skin assessments, to ensure completion and accuracy. Any identified issues will be corrected at that time.</p> <p>Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.</p>	7/17/2015



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F 314	<p>Continued From page 24 area. However, there was no description of the open area.</p> <p>A review of a physician's order dated 03/24/15 indicated stage 3 pressure sore of the coccyx and an order to off-load wound, reposition, and use silver sulfadiazine (topical cream), calcium alginate (a water-insoluble cream), and mepilex border dressing to pressure wound on Tuesday/Thursday/Saturday.</p> <p>A review of weekly wound measurements dated from 03/03/15 to 03/24/15 revealed there were no wound measurements or descriptions for the open area on Resident # 1's buttocks.</p> <p>A review of a physician's order dated 06/09/15 indicated stage 4 pressure sore of the coccyx and to apply santyl (an ointment used to remove dead skin from wounds) and then twice daily a wet to dry dressing with Dakin's solution (used to wet certain types of dressings for wounds).</p> <p>During an interview on 06/17/15 at 12:03 PM Resident #1's family member stated the resident's skin was very fragile and tore very easily. She explained Resident #1 had a sore on her bottom that had healed in March. The family member explained the sore had re-opened around the first of April because the resident sat on in her wheelchair so much and caused pressure to the area. The family member stated it had a dressing on it and it was being changed once a day. The family member further stated she had requested to have a second opinion of the pressure sore.</p> <p>During an observation of wound care on 06/17/15 at 2:48 PM Nurse #3 removed Resident #1's brief</p>	F 314		
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F 314	<p>Continued From page 25</p> <p>and cleaned an open area on the resident's buttocks with wound cleanser. The open area was oozing a small amount of blood around the edges and Nurse #3 applied a Dakin's solution inside the open area and secured the dressing to the resident's skin with gauze and paper tape dressing.</p> <p>During an interview on 06/17/15 at 3:22 PM Nurse #3 explained the facility does not have a wound nurse and the hall nurses were responsible for doing there resident's wound care. Nurse #3 explained the wound on Resident #1's bottom was a large opened area with necrotic tissue (dead tissue with inadequate blood supply) and had been classified as a stage 4 pressure sore. She stated the dressing changes were supposed to be done once daily with santyl and twice daily with a Dakin's solution wet to dry dressing. She stated she did not change the dressing using the santyl ointment because she had forgotten and was nervous. She indicated she was not sure when the santyl ointment dressing was last changed and she had not measured the area because she was unaware she needed to do measurements.</p> <p>During an interview on 06/18/15 at 10:07 AM with Nurse #4 she stated she had changed Resident #1's dressing on her buttocks on Monday 06/15/15 because the dressing had come off. She described the wound as circular and approximately 4 centimeters long x approximately 3 centimeters wide and the wound was clean. She stated the nurses did not measure any wounds and Resident #1's wound was still classified as thick necrotic tissue.</p> <p>During an observation of wound care on 06/18/15</p>	F 314		

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F 314	<p>Continued From page 26</p> <p>at 10:37 AM Nurse #4 showed the Nurse Mentor/Unit Manager the open area on Resident #1's buttocks and provided wound care.</p> <p>During an interview on 06/18/15 at 10:45 AM the Nurse Mentor/Unit Manager stated the wound on Resident #1's buttocks was a stage 4 pressure sore and was not necrotic tissue. She also verified documentation on weekly skin integrity sheets was unclear and there should have been documentation as to exactly where the wound was located and the stage of the wound.</p> <p>During an interview on 06/18/15 at 12:36 PM the Director of Nursing explained the nurses assessed pressure sores but did not do wound measurements each week. She explained the nurse who was assigned to the resident did the weekly skin assessments and if they saw something it was her expectation for them to report it to the nurse mentor/unit manager and she should report it at the daily meeting. She further explained she expected the nurse aides (NAs) to report concerns about resident's skin when they gave residents showers and baths and the nurses should report any new skin concerns to the physician.</p> <p>During an interview on 06/19/15 at 9:15 AM the facility's physician stated he was not aware of Resident #1's wound on her buttocks until staff told him about it after he had arrived at the facility that morning. He stated he assessed wounds when residents were admitted to the facility or when the nurse had questions and he expected to be called if a resident's condition worsened.</p>	F 314		
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