

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G610	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 N DUNN BLOOMINGTON, IN 47408
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W000000	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00135018 completed on 10/4/13.</p> <p>This visit was in conjunction with the full annual recertification and state licensure survey.</p> <p>Complaint #IN00135018: Not Corrected.</p> <p>Survey dates: February 6, 7, 10, 11 and 12, 2014</p> <p>Facility number: 001172 Provider number: 15G610 AIM number: 100240110</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/19/14 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 15 incident/investigative reports reviewed affecting 2 of 3 clients in the sample (D and E), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients, ensure the staff immediately reported abuse and neglect to the administrator and take appropriate corrective action with staff for failing to immediately report neglect.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 2/6/14 at 1:02 PM and indicated the following:</p> <p>1) On 2/8/14 at 4:30 PM, client E was standing in front of the television in the living room. Staff asked client E to move but before staff could assist her client D pushed client E. Client E was pushed into a staff and bumped her head on the staff. There was a slight red mark noted. The Bureau of Developmental Disabilities Services (BDDS) report, dated 2/9/14, indicated, "Since the incident, [client D] has pushed [client E]</p>	W000149	To correct the deficient practice, an investigation will be completed for the incident that occurred on 1/4/14. All of the other above incidents has been investigated, resulting in the following recommendations: 1& 2. Client D has 1:1staffing within eyesight, or his bedroom door if he is having private time, at all times during waking hours. Client D has a door alarm on his bedroom door to alert overnight staff when he opens his door. 4 Staff on duty was released from employment. A monitoring schedule of observations was implemented. Functional assessments for individuals involved reviewed to ensure appropriate programming is in place. 5 Staff involved released from employment, after review of incident by HR Director and Director of Residential Services. Staff who reported the incident, as well as ND/Q, were retrained on reporting incidents immediately. 6 Staff involved was terminated. Client D's RSP to be revised to include fecal smearing as a targeted behavior. To prevent the deficient practice from recurrence, all staff will be retrained on reporting incidents, including those involving peer aggression, to administrative staff. Additional training will be	03/14/2014			

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	<p>a few more times. She has not been hurt by the pushes. [Client D] likes to rough house with staff and peers. He does not communicate verbally and will pull or push people to indicate what he wants. [Client D] has a one on one staff that were (sic) not able to get between the peers quickly enough. Writer (Quality Assurance Director - QAD) has requested that [client D's] staff keep him within arm's length to prevent any further pushing."</p> <p>On 2/10/14 at 9:39 AM, the QAD indicated client to client aggression was considered abuse. The QAD indicated the facility should prevent abuse of the clients. The QAD indicated the facility had a policy prohibiting abuse of the clients.</p> <p>On 2/7/14 at 1:55 PM, the Home Manager (HM) indicated client to client aggression was abuse.</p> <p>2) On 1/31/14 at 7:50 PM, staff #4 heard an unusual noise coming from client E's bedroom. Staff #4 went to check on client E and found client D, fully clothed, on top of client E, who was naked, "humping" against her. Client E was upset and crying. The Unusual Incident Report, dated 1/31/14,</p>		<p>added to the new employee orientation curriculum to include the importance of when and how to report instances of alleged abuse, including instances of peer aggression. All Directors of Services will meet with the CEO weekly to review the status of all investigations, including implementation of recommendations, for a period of no less than 3 months. Ongoing monitoring will be accomplished by monthly review of investigations and completion of recommendations by all Directors of Services with the CEO.</p>				

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	<p>indicated, "At approximately 7:50 PM, staff (myself [staff #4]) found [client E] undressed in upstairs living room with supervising staff [#5] and other customers. [Client E] was escorted downstairs to med room for meds, then to bedroom after meds were consumed. I noticed there were no bed sheets on [client E's] bed so I asked [staff #5] if she could assist [client E] with the task of making her bed. I returned to the med room to help [staff #9] finish putting together meds for the next customer, [client C]. I left the med room to retrieve [client C] but before I made it up the stairs I heard a strange, squeaking noise coming from [client E's] bedroom. Entering her room to investigate, I found [client D] in [client E's] bed. [Client E] was undressed and [client D] was on top of her, humping. I pulled [client D] off of [client E] and escorted him upstairs to his room. At this point, I saw [staff #5] on the couch drinking her coffee. I grabbed bed sheets to bring to [client E's] room since that task had still not been accomplished and tried to comfort [client E] as she was crying. *When I had asked [staff #5] to assist [client E]</p>			

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	<p>she stated that she didn't want to leave the kids alone upstairs but I told her they would be fine for a few minutes." The investigation, dated 2/7/14, indicated, "During the evening medication pass, staff heard a noise coming from [client E's] room when going to get another customer for meds. Upon reaching her room, staff discovered [client D] on top of [client E] who was nude in her bed. [Client D] was clothed and immediately removed." The investigation indicated, "It has been confirmed that [client E] was found in her bed with [client D], a male peer on top of her clothed while she was nude. The best approximation is that the incident occurred in a minute or two time. [Staff #4] had tucked [client E] in bed, went to the med room to help prepare [client C's] meds, went to go get [client C], and heard a strange noise coming from [client E's] room. [Staff #9], was in the med room with [staff #4] as she was being med trained. The other staff, [staff #5] was upstairs at the time of the incident and thought [client D] was downstairs for meds. [Staff #5] was not aware that [client E] was naked in the living room. [Staff #9]</p>						

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	<p>did not observe any of the incident, but received reports from [staff #4] when she returned to the med room that supports the incident." The facility substantiated (the findings support the alleged event as described) neglect by staff #5. The investigative report indicated, "[Staff #5] will be released from employment due to failing to respond to a co-workers (sic) requests for assistance (with getting [client E] clothed) and being aware of all customer's whereabouts."</p> <p>On 2/10/14 at 8:56 AM, the QAD indicated staff #5 should have been supervising the clients. The QAD indicated staff needed to be trained on staff deployment, peer proximity and situational awareness. On 2/10/14 at 9:39 AM, the QAD indicated the facility substantiated neglect and staff #5 was terminated. The QAD indicated the facility should prevent neglect of the clients. The QAD indicated the facility had a policy prohibiting neglect of the clients.</p> <p>3) Client D's Behavior Observations,</p>						

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	<p>dated 1/4/14 (8:00 AM to 10:00 PM shift), indicated, "When peer arrived home, [client D] became very aggressive (sic) towards her (client E) pushing/shoving/hitting. This continued all shift also kicked peers on couch." The Behavior Observations report indicated "No" for if an Unusual Incident Report was completed and the Q (Qualified Intellectual Disabilities Professional) was notified. The form was completed by staff #7. There was no documentation the incident was reported to administrative staff and BDDS and an investigation was conducted.</p> <p>On 2/7/14 at 1:55 PM, the HM indicated client to client aggression was considered abuse. The HM indicated the incident should have been reported to administrative staff, BDDS and investigated by the facility.</p> <p>4) On 12/12/13 at 5:00 PM, the BDDS report, dated 12/13/13, indicated, "Staff reported that she [staff #12], [staff #11] and one other staff [staff #5] were getting ready for an outing with all the</p>						

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	<p>consumers. Everyone was ready to go with the exception of [client E]. Staff was having a hard time getting [client E] ready to go so reporter [staff #12] and other staff [#5] took the rest of the customers to the van to get them loaded up. Reporting party went back into the house to see if she could be of assistance to [staff #11] with [client E]. Staff reported, "When I walked inside I seen (sic) [staff #11] with her hand on [client E's] face pushing back as she was forcefully pulling [client E's] arm through the jacket against her will to get it on." The investigation, dated 12/19/13, indicated, "The allegation that [staff #11] put her hand on [client E's] face while trying to put her coat on is substantiated, based on direct observation of this event by another DSP (Direct Support Professional). This is a violation of [client E's] rights, physical intervention should only be used as a last resort in the event that an individual is at risk of harming herself or another individual. The staff who made the allegation, [staff #12], did immediately report the incident to the ND/Q (Network Director/Qualified</p>			

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	<p>Intellectual Disabilities Professional) at the holiday party. The ND/Q did not take action until the following morning, upon reading the written incident report. As a result, [staff #11] continued working for a brief period of time alone with [client E], even though an allegation had been made. This writer is not sure how clear the information about the incident was communicated by [staff #12] to [ND/Q], as the party environment was quite noisy and chaotic. [QAD] provided training right away to [ND/Q] to ensure that immediate action is taken in the event that she receives allegations in the future." The investigation indicated staff #11's employment was terminated on 12/20/13.</p> <p>On 2/6/14 at 12:14 PM, the QAD indicated the incident should have been reported to the administrator immediately. The QAD indicated abuse was substantiated and staff #11 was released from employment. On 2/10/14 at 9:39 AM, the QAD indicated the facility should prevent abuse of the clients. The QAD indicated the facility had a policy prohibiting abuse of the clients.</p>						

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	<p>5) On 11/18/13 at 3:00 AM, the HM arrived at the group home to take over for the overnight shift (staff #10). The HM noticed client D's audio monitor was turned off. The HM went into client D's bedroom. Client D had smeared feces on his bathroom walls and dried feces on his hands. The HM cleaned up the bathroom and assisted client D with washing his hands. Client D's Baby Monitor Protocol, dated 4/24/13, indicated the monitor should be used when client D was sleeping and staff should carry the monitor with them at all times due to GERD (Gastroesophageal reflux disease) and seizure disorder. The protocol indicated staff were to check on client D every 30 minutes meaning "look at [client D] from a close distance to ensure he is sleeping normally." Client D's Sleep Chart, dated November 2013, indicated staff #10 completed bed checks at 9:30 PM, 10:00 PM, 10:30 PM, 11:00 PM and 11:30 PM. The investigative report indicated, "The chart ends at 11:30 PM so there doesn't appear to be documentation for bed checks from 12 AM - wake time." The investigative report, dated 11/22/13, indicated the facility substantiated neglect. The Findings indicated, "The allegation of</p>				

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	<p>neglect of [client D] by [staff #10] has been substantiated. [Staff #10] neglected to meet the needs of the customer while working her overnight shift on the night of 11/18/2013. She failed to turn the baby monitor on and self reported that she monitored the customer by leaving his bedroom door open. BM (bowel movement) was present on the walls of his bathroom and on his hands when the relief staff arrived at 3 AM." Staff #10's employment was terminated on 12/4/13. The HM reported the incident to administrative staff at 11/18/13 at 8:00 AM. There was no documentation the facility identified the failure of the HM to immediately notify administrative staff of suspected neglect. There was no documentation the facility took corrective action with the HM for failing to immediately report suspected neglect to the administrator.</p> <p>On 2/6/14 at 1:18 PM, the QAD indicated the HM did not immediately report the incident to administrative staff. The QAD indicated the HM should have reported the incident immediately. On 2/10/14 at 9:39 AM, the QAD indicated facility substantiated neglect and staff #5 was terminated. The QAD indicated the facility should</p>			

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	<p>prevent neglect of the clients. The QAD indicated the facility had a policy prohibiting neglect of the clients.</p> <p>On 2/7/14 at 2:00 PM, the HM initially indicated she immediately reported the incident to the QAD. The HM then indicated she did not immediately report the incident. The HM indicated she reported the incident to the QAD at 8:00 AM. The HM indicated the incident was not life threatening and the HM did not want to wake up the QAD. The HM indicated she noticed the monitor was not on after staff #10 left the group home.</p> <p>On 2/6/14 at 12:33 PM, a review was conducted of the facility's Individual Rights and Protection policy, revised in October 2013. The policy indicated, in part, "The investigation must be initiated within 24 hours of the initial report. The investigation shall include the following: Review of incident reports. Interview and/or observation with customer and/or guardian and/or advocate. Interview with other customers, as needed. Interview of all parties involved,</p>				

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	<p>including, whenever possible: person suspected of violation, persons who witnessed violation, other staff who provide service to the individual. The individual shall submit the written report to the Chief Operating Officer and the Director of Support Services. The report shall consist of: review of any documentation regarding incident, personal interviews with all individuals having knowledge of the incident, review of agency practices, a summary of findings investigation has discovered, and recommendations/action plan.</p> <p>Recommendations will explicitly define: who is to complete the recommendation and the timeframe for completion. Who is to receive and monitor the completed recommendations (Director of Services and Human Resources if applicable)."</p> <p>The policy indicated, "The staff or consultant making the initial report should document the incident or reason for suspicion on an Unusual Incident Form within 24 hours of the report. All Unusual Incident Forms will be submitted to the Network Director/QDDP and a copy given to the Director of Support Services. The staff</p>			

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	receiving the report will immediately inform the Administrator (Chief Operating Officer, Chief Executive Officer or Director of Services), and the Director of Support Services, who will determine who will conduct the investigation. 1. Investigations involving customers residing in group home setting (ICF/MR) must be completed and results reviewed by the Administrator (Chief Operating Officer or Director of Services) within five working dates of the incident." The January 2014 policy on Behavior Support indicated, in part, "LifeDesigns prohibits the use of unnecessary medications, corporal punishment, physical abuse, the application of electric shock or use of any painful or noxious stimuli, the withdrawal of food and other essentials of human life, seclusion in a locked room, swearing or other verbal threats, discipline dealt by another LifeDesigns customer, mechanical restraints, denial of religious activity, contingent exercise, negative practice, overcorrection, visual or facial screening, denial of health related necessities, degrades and individual 's			

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W000249	<p>dignity or use of anything that inflicts pain or humiliation." The Reporting Abuse/Neglect/Exploitation policy, dated September 2013, indicated, in part, "Any employee or consultant having knowledge of an incident of abuse and/or neglect and any suspected incident of abuse and/or neglect must report to the Network Director or the emergency pager upon discovery."</p> <p>This deficiency was cited on 10/4/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 3 clients in the sample (C and E) and 2 additional clients (A and B), the facility failed to ensure staff</p>	W000249	To correct the deficient practice and ensure it does not recur, staff will be retrained on implementation of all individual program plans. For those IPPs	03/14/2014			

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	<p>implemented the clients' program plans as written for increasing their 1) communication skills and 2) money management skills.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 2/6/14 from 6:20 AM to 8:30 AM. Client A, upon arrival to the group home, was sitting in his bedroom cutting paper with scissors. At 7:50 AM, client A went from his basement bedroom to the main floor. During the observation, client A was not prompted to use his choice board. During the observation, client E was not prompted to use her card or choice board.</p> <p>On 2/6/14 at 6:30 AM, staff #8 indicated client A had been awake since 4:00 AM. Staff #8 indicated this was not unusual but did not occur every night. Staff #8 indicated client A enjoyed sitting in his room cutting paper.</p> <p>A review of client A's Individual Program Plan (IPP), dated 3/8/13, was conducted on 2/10/13 at 9:21 AM. Client A's IPP indicated, "[Client A] will utilize more than one form of communication and be able to more accurately express his wants, needs, and emotions. <u>PROCEDURE</u>: 1. Staff</p>		<p>that are not implemented daily, such as community purchases, a visual schedule will be put in place to assist staff to remember which IPPs need to be implemented. The ND/Q or Team Manager will observe staff at least 5 times per week for a period of no less than one month to ensure all IPPs for all individuals living in the home are implemented as written, providing training and support to staff as needed. If no concerns are noted, the observations by the ND/Q can be reduced to a minimum of twice per week for a period of one month. The Team Manager will conduct observations of DSP interactions with individuals, and implementation of IPPs, on an ongoing basis while working alongside DSPs in the home. Ongoing monitoring will occur through weekly observations by the ND/Q to ensure implementation of all IPPs as written.</p>				

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	<p>should assist [client A] in using his choice boards to indicate his wants, needs, or feelings throughout the day.</p> <p>2. When [client A] is attempting to indicate he wants something or is upset, staff should remind [client A] to use his choice boards. 3. Staff should have [client A] use the choice board to assist him with making his daily schedule. 4. When [client A] chooses a PEC (picture exchange card) card from the board, staff should prompt him to say "I want ____" and then say the word aloud as he chooses the card. 5. This goal will be considered met if at some point in the day [client A] is able to indicate a need/want or feeling using the boards, say "I want" and then say the PEC card word aloud."</p> <p>A review of client E's IPP, dated 2/14/13, was conducted on 2/10/14 at 9:56 AM. The plan indicated, "[Client E] will utilize more ways of communication to be able to effectively communicate with more people and more easily express her wants and needs. CURRENT LEVEL: [Client E] is non-verbal and communicates by leading people to what she wants or simply going to the item and taking it. [Client E] will utilize a PEC card or choice board one time daily at free time to communicate with staff 65% of the</p>			

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	<p>time for three consecutive months with verbal and environmental cues."</p> <p>On 2/7/14 at 2:00 PM, the Home Manager (HM) indicated the clients should use their choice boards both in the evening and the morning. The HM indicated the clients had goals (training objective) to use the choice board.</p> <p>On 2/10/14 at 9:39 AM, the Quality Assurance Director (QAD) indicated the clients' training objective for using the choice board should be implemented in the morning and evening.</p> <p>2) A review of the clients' finances was conducted on 2/6/14 at 3:23 PM and indicated the following:</p> <p>Client A did not have an Individual Petty Cash Ledger. There was no documentation client A accessed his finances since October 2013. A review of client A's IPP, dated 3/8/13, was conducted on 2/10/14 at 9:21 AM. The IPP indicated, "[Client A] will hand money to the cashier and wait for change. <u>DEVELOPMENTAL OUTCOME</u>: [Client A] will learn that something must be exchanged in order to receive something at a store. <u>PROCEDURE</u>: 1. Using the choice PEC cards, staff will ensure [client A]</p>						

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	<p>adds to his schedule a community outing in which he can make a purchase on the above assigned day. 2. Staff will assist [client A] with making the purchase. When it is time to pay, staff will hand [client A] his money and prompt him to hand the money to the cashier. 3. Staff should encourage [client A] to wait while the cashier gets his change and then prompt him as necessary to take the change. 4. This will only be considered met if [client A] hands the cashier the money <u>AND</u> gets the change back from them."</p> <p>Client B's Petty Cash Ledger, dated 11/9/12 to 9/1/13, indicated the most recent withdrawal occurred on 8/12/13 for money for a school outing. There was no documentation client B accessed his money since 8/12/13. Client B's IPP, dated 6/14/13, indicated, "DEVELOPMENTAL OUTCOME: [Client B] will be more involved in the transaction process when making a purchase. PROCEDURE: 1. Using the choice PEC cards, staff will ensure [client B] adds to his schedule a community outing in which he can make a purchase on one time each week. 2. Staff should communicate with the TM (team manager) ahead of time to ensure access to funds. 3. Staff will assist [client B] with making the purchase</p>			

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	<p>encouraging him to participate in any part of the transaction. 4. Staff should encourage [client B] to wait while the cashier gets his receipt and/or change and then prompt him as necessary to take it from the cashier. 5. This goal will be considered met if [client B] removes the receipt and/or from the cashier's hand."</p> <p>Client C's Petty Cash Ledger, dated 10/25/12 to 9/1/13, indicated the most recent withdrawal occurred on 8/12/13 for money for a school outing. There was no documentation client C accessed his money since 8/12/13. Client C's IPP, dated 6/14/13, indicated, "DEVELOPMENTAL OUTCOME: [Client C] will be more involved in the transaction process when making a purchase. PROCEDURE: 1. Using the choice PEC cards, staff will ensure [client C] adds to his schedule a community outing in which he can make a purchase on one time each week. 2. Staff should communicate with the TM ahead of time to ensure access to funds. 3. Staff will assist [client C] with making the purchase encouraging him to participate in any part of the transaction. 4. Staff should encourage [client C] to wait while the cashier gets his receipt and then prompt him as necessary to take it from the cashier. 5. This goal</p>						

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	<p>will be considered met if [client C] removes the receipt from the cashier's hand."</p> <p>Client E's Petty Cash Ledger, dated 7/31/13 to 10/2/13, indicated the most recent withdrawal occurred on 10/2/13. There was no documentation client E accessed her money since 10/2/13. Client E's IPP, dated 2/14/13 indicated, "DEVELOPMENTAL OUTCOME: [Client E] will become familiar with transactions and the steps involved in making a purchase. CURRENT LEVEL: [Client E] currently shows no understanding of money, how to purchase things, or the steps involved in purchases. When prompted to go to the cashier for her purchase [client E] has little patience for waiting to pay for her purchase. OBJECTIVE: On a weekly outing, [client E] will hand money to the cashier to make a purchase."</p> <p>On 2/11/14 at 3:23 PM, the QAD indicated the clients' program plans should be implemented as written for their money management training objectives.</p> <p>This deficiency was cited on 10/4/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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