

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER BEARDSLEY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 27833 CR 24 ELKHART, IN 46517
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 19, 20, & 21, 2014</p> <p>Facility Number: 004353 Provider Number: 004353 AIM Number: N/A</p> <p>Survey Team: Lora Swanson, RN-TC Debora Kammeyer, RN</p> <p>Census bed type: Residential: 19 Total: 19</p> <p>Census payor type: Private: 19 Total: 19</p> <p>Sample: 7</p> <p>These deficiencies are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on August 29, 2014, by Brenda Meredith, R.N.</p>	R000000	Disclaimer For Plan of Correction: Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth In this allegation by the survey agency.	
R000033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance			

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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	<p>(h) The facility must furnish on admission the following:</p> <p>(1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility.</p> <p>(2) The most recently known addresses and telephone numbers of the following:</p> <p>(A) The department.</p> <p>(B) The office of the secretary of family and social services.</p> <p>(C) The ombudsman designated by the division of disability, aging, and rehabilitation services.</p> <p>(D) The area agency on aging.</p> <p>(E) The local mental health center.</p> <p>(F) Adult protective services.</p> <p>The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation and interview, the facility failed to ensure the pertinent advocacy groups and contact information was displayed in an easily readable format and location. This potentially affected all residents in the facility and/or their family members.</p> <p>Finding includes:</p> <p>On 8/19/14 at 10:00 A.M., an observation of the front lobby and the foyer was conducted. The advocacy groups and contact information was displayed in a picture frame (8 x 10) mounted on the wall 6 foot from the floor in the front</p>	R000033	<p>Affected Residents: No Residents were affected. Identificaiton: Resident's Right sposter providing the Department, the Office of Secretary of Family and Social Services, The Ombudsmen designated by the Division of Disability, Aging and Rehabilitation Services, The Are Agency on Aging, The Local mental Health Center and Adult Protective Services was placed at eye level in a visual area. Measures: The Executive Director, or designee, will review the location and information with resident's in Resident Council meeting. Families will be notified via letter from the Executive</p>	09/30/2014			

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R000042	<p>lobby. When standing and facing the wall where the information was displayed it was not at eye level.</p> <p>On 8/19/14 at 2:50 P.M., a resident (name unknown) was sitting in the front lobby in her scooter and was taken to the area where the 8 x 10 picture frame contained the advocacy information. The resident indicated there was no way she could read the information listed because it was too far away and too high up on the wall. She also indicated she had no idea the information was located on the wall in the lobby.</p> <p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to ensure the survey results were easily assessable and their location easily identified. This potentially affected all residents in the facility and/or their family members.</p>	R000042	<p>Director.Monitoring: The Executive Director or designee will review Resident Council Notes after meetings for 6 months to ensure Resident's have a clear visual of the information and finding will be reported to the Quality Committee for reiview and recommendation in change of frequency based on findings.</p> <p>Affected Residents: None were identified to be affected.Identification: Resident's were interviewed and educated during Resident council as to location of Survey Results. Survey Binder is identified with label and in Visual</p>	09/30/2014			

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R000116	<p>Findings include:</p> <p>On 8/19/14 at 10:00 A.M., an observation of the front lobby and the foyer was conducted, there were no survey results observed and no notice or sign posted to let visitors or resident's know where to locate the survey results.</p> <p>On 8/19/14 at 2:45 P.M., an interview with the DON (Director of Nursing) indicated she had not seen a posting for the survey book and was unsure where it was kept in the facility. The DON further indicated the survey book should be readily available and in an area assessable to resident's and/or their family members.</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interviews, the facility failed to ensure 2 of 5 employee files reviewed contained documentation of references. (Employee #8 and Employee #9)</p>	R000116	<p>Location.Measures: Residents and Families will be educated during Admission and at Resident Council Meetings as to the location of the Survey Results Binder.Monitoring: The Executive Director or Designee will monitor location of Survey Results daily during morning Rounds and identify that it is in place during Daily Stand Up Meeting, Monday-Friday.</p> <p>Affected Residents: There were not any Residents identified to be affected.Identification: Current Employee Files will be audited for completeness including 2 reference checks.Measures: The Executive Director or designee will be responsible to</p>	09/30/2014			

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	<p>Findings include:</p> <p>During the review of personnel files, conducted on 8/21/14 between 11:00 A.M.- 4:00 P.M., the personnel file of Employee #8, with a hire date of 6/25/14 and Employee #9, with a hire date of 7/7/14, had documentation of only one reference check being completed when they were hired.</p> <p>On 8/21/14 at 4:00 P.M., review of a form titled "Section 1" from the employee file received from the Director of Nursing indicated "...Completed reference checks (Minimum of two)..."</p> <p>On 8/21/14 at 4:10 P.M., an interview with the Director of Nursing indicated that new employees should have three reference checks prior to starting employment.</p> <p>On 8/21/14 at 4:30 P.M., an interview with the Executive Director indicated she just started her employment at the facility recently, she further indicated updating the employee files was the responsibility of the previous Executive Director and now it will be her responsibility and further indicated she is aware the employee files are "lacking here" and need updated.</p>		<p>assure that New Employee files are complete and kept up to date. Current Employee Files will be Audited for completeness. Monitoring: The Executive Director or designee will review new Hire records at Employee Start Date to ensure pre-hiring requirements are met. Audits will then be completed monthly for 6 months to ensure pre-hiring requirements and reference checks were completed and continue to be. Findings will be reported to Quality Committee for review and recommendation for change in frequency will be based upon audit.</p> <p>A new ED is in place and was educated regarding the importance of 3 reference checks, on all new employees.</p> <p>All employee files were audited. Employees not having 3 references were updated.</p>				

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure 10 of 17 licensed employee files reviewed contained documentation of current CPR (Cardio Pulmonary Resuscitation) certification. (Employee #4, 5, 6, 7, 8, 9, 11, 13, 14, and 15)</p> <p>Findings include: During the review of personnel files,</p>	R000117	<p>Affected Residents: There were not any Resident's found to be affected. Identification: Executive Director or Designee will audit employee files for CPR Status, identifying those who need CPR Status updated. Measures: The Executive Director or designee will complete Audit of all New Employee Files prior to Employee Start date to ensure that CPR Status is known and Plan in place if CPR needs updated. Executive Director or Designee will continue</p>	10/31/2014			

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	<p>conducted on 8/21/14 between 11:00 A.M.- 4:00 P.M., the following was not located in the personnel files:</p> <p>Employee #4, a nursing staff member with a hire date of 6/30/14, had no CPR certification.</p> <p>Employee #5, a nursing staff member with a hire date of 1/6/14, had no CPR certification.</p> <p>Employee #6, a nursing staff member with a hire date of 6/19/14, had no CPR certification.</p> <p>Employee #7, a nursing staff member with a hire date of 6/15/14, had no CPR certification.</p> <p>Employee #8, a nursing staff member with a hire date of 6/25/14, had no CPR certification.</p> <p>Employee #9, a nursing staff member with a hire date of 7/7/14, had no CPR certification.</p> <p>Employee #11, a nursing staff member with a hire date of 12/27/13, had no CPR certification.</p> <p>Employee #13, a nursing staff member with a hire date of 1/15/14, had a CPR certification that outdated on 2/2014.</p> <p>Employee #14, a nursing staff member with a hire date of 6/11/14, had no CPR certification.</p> <p>Employee #15, a nursing staff member with a hire date of 4/18/14, had no CPR certification.</p>		<p>to audit employee files for six months and findings will be reported to the Quality committee for review and recommendation to change frequency based on audit findings. CPR will be updated for needed staff members by 10/31/14.</p> <p>A new ED is in place and was educated regarding the importance of collecting and keeping CPR cards on file on all new employees.</p> <p>All employee files were audited. Employees not having CPR cards were obtained.</p>				

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R000119	<p>On 8/21/14 at 2:30 P.M., a review of the nursing staff schedule, dated July 27 through August 21, 2014, received from the Administrator indicated the facility did not have a CPR certified staff member on duty during the following days: July 27, 28, 29, 30 and 31, August 1, 4, 5, 7, 8, 9,10,11,12,13,14,15,16,18,19 and 21, 2014.</p> <p>On 8/21/14 at 3:00 P.M., when the DON (Director of Nursing) was asked for the CPR certification information. No documentation was made available to review.</p> <p>On 8/21/14 at 4:30 P.M., an interview with the Executive Director indicated she was aware there needs to be one employee with a current CPR and first aid certification on the site at all times. She further indicated updating the employee files will be her responsibility and also indicated she is aware the employee files were "lacking here" and need updated.</p> <p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p>			

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	<p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on interview and record review, the facility failed to provide orientation training regarding abuse for 7 of 10 employees prior to working independently in the facility. In addition, the facility failed to ensure the required dementia in-servicing was completed for</p>	R000119	Affected Residents: There were not any Resident's found to be affected. Identification: Executive Director or Designee will audit employee files for completeness of General Orientation including Abuse and Dementia Education, identifying those who need	09/30/2014

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	<p>2 of 10 employees. (Employee #1, Employee #2, Employee #4, Employee #8, Employee #10, Employee #13, Employee #16, Employee #17 and the Director of Nursing)</p> <p>Findings include:</p> <p>1. On 8-19-14 at 1:00 P.M., the Administrator provided a policy titled "Identification Of An Event That May Constitute Abuse" undated, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Notify the Administrator and Director of Nursing Services (DNS)...."</p> <p>During an interview on 8-20-14 at 9:55 A.M., Employee #1 indicated she was unaware of the types of abuse. When questioned about her orientation and/or training when hired she couldn't recall being trained about abuse. Employee #1 further indicated she had "no idea" whom to report an allegation of abuse to.</p> <p>On 8-20-14 at 10:30 A.M., a review of Employee #1's personnel file had no documentation indicating orientation nor in-servicing regarding abuse since her hire date of 2-17-14.</p> <p>On 8-20-14 at 11:10 A.M., the Administrator provided a form titled</p>		<p>Education.Measures: The Executive Director or designee will complete Audit of all New Employee Files for completeness immediately following their General Orientation. Executive Director or Designee will continue to audit employee files for six months and findings will be reported to the Quality committee for review and recommendation to change frequency based on audit findings.</p> <p>A new ED is in place and was educated regarding the importance dementia and abuse orientation on all new employees.</p> <p>All employee files were audited. dementia and abuse orientation were orientated.</p>				

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	<p>"Staff Orientation and Training Outline", dated 2/2007, and indicated the outline was the one currently used by the facility. The outline indicated on Day 1 the employee would be instructed about abuse, its definition and examples by the Resident Director. The Administrator indicated the employee would take a test over the material discussed in orientation regarding abuse and the results of the abuse test would be kept in the employee's file.</p> <p>During an interview, on 8-20-14 at 2:40 P.M., the DON (Director of Nursing) indicated all staff should be instructed on abuse during their orientation process. The DON reviewed Employee #1's personnel file and could not locate documentation indicating the Employee #1 had the required abuse training.</p> <p>2. During a review of the employee files, conducted on 8-21-14 between 1:00 P.M. - 3:00 P.M., the following documentation was not located in the personal files:</p> <ul style="list-style-type: none"> a. Employee #2, a nursing staff member with a hire date of 3-23-14, had no abuse training. b. Employee #4, a nursing staff member with a hire date of 6-30-14, had no abuse training. c. Employee #8, a nursing staff member with a hire date of 6-25-14, had no abuse 			

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R000123	<p>training.</p> <p>d. Employee #10, with a hire date of 7-7-14, had no abuse training.</p> <p>e. Employee #13, a nursing staff member with a hire date of 1-15-14, had no dementia training.</p> <p>f. Employee #16, a nursing staff member with a hire date of 1-7-14, had no dementia training.</p> <p>g. Employee #17, a nursing staff member with a hire date of 2-17-14, had no abuse training.</p> <p>h. The DON with a hire date of 7-15-14, had no abuse training.</p> <p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.</p>						

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	<p>Based on record review and interview, the facility failed to ensure 2 of 5 personnel files reviewed contained documentation the employees received a general orientation to the facility. (Employee #8 and Employee #9)</p> <p>Findings include:</p> <p>During the review of personnel files, conducted on 8/21/14 between 11:00 A.M.- 4:00 P.M., the personnel file of Employee #8, with a hire date of 6/25/14, had no general orientation documentation. Employee # 9, with a hire date of 7/7/14 had no general orientation documentation.</p> <p>On 8/21/14 at 3:00 P.M., when the DON (Director of Nursing) was asked for the general orientation information no documentation was available to review.</p> <p>On 8/21/14 at 4:00 P.M., review of the "General Orientation Record" policy received from the DON indicated "...It is the expectation...that all staff receives a timely and thorough General Orientation...General orientation is a 2-day process required for ALL new employees...The Executive Director is responsible for ensuring a quality general orientation for new employees...."</p>	R000123	<p>Affected Residents: There were not any Resident's found to be affected. Identification: Executive Director or Designee will audit employee files for completeness of General Orientation identifying those who need follow up. Measures: The Executive Director or designee will complete Audit of all New Employee Files for completeness immediately following their General Orientation. Executive Director or Designee will continue to audit employee files for six months and findings will be reported to the Quality committee for review and recommendation to change frequency based on audit findings.</p> <p>A new ED is in place and was educated regarding the importance of completing general orientation on all new employees.</p> <p>All employee files were audited. Employees missing general orientation were orientated.</p>	09/30/2014			

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R000215	<p>On 8/21/14 at 4:30 P.M., an interview with the Executive Director indicated she just started her employment at the facility recently, she further indicated updating the employee files was the responsibility of the previous Executive Director and now it will be her responsibility and also indicated she is aware the employee files were "lacking here" and need updated.</p> <p>410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on interview and record review the facility failed to assess a resident when they returned to the facility from a stay at</p>	R000215	Affected Resident: 1 Resident was found to be affected. This Resident now has appropriate assessments and services in	09/30/2014

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	<p>a local nursing home for 1 of 7 residents reviewed. The facility also failed to retain the Home Health Wound Assessments in the facility. (Resident #5)</p> <p>Findings include:</p> <p>On 8-19-14 at 1:30 P.M., a review of the clinical record for Resident #5 was conducted. The record indicated the resident was admitted on 9-16-11 with a re-admission on 6-6-14. The diagnoses included but were not limited to: history of blood cancer, deaf in right ear, and hypertension.</p> <p>A Physician's order, dated 6-8-14, indicated the resident was to receive physical therapy, wound care and pain management by a Home Health Care provider.</p> <p>On 8-21-14 at 9:15 A.M., a review of the Service Assessment dated 5-28-14 was completed prior to the resident's return to the facility. A section titled "Special Service" indicated resident would need physical therapy and a home health provider to apply a dressing to the resident's left shin and the left heel. The comments section indicated resident had history of cellulitis and a decubitus ulcer on the left leg.</p>		<p>place. Identification: Executive director or designee will audit the Charts of Residents who have been discharged to Acute Care or SNF and readmitted will be audited to ensure pre-admission evaluation and current admission evaluation is available to compare with the current condition of resident to assure that the care the resident requires is within range of personal care, supervision and outside Services are appropriate. Measures: The Executive Director or designee will audit all new residents files to ensure an evaluation is completed upon admission. Care Service Manager or designee will document weekly on all Resident's with a third party provider to identify need and status. Monitoring: The Executive Director or designee will review New Admission Records monthly for six months to ensure assessment was completed and findings will be reported to the Quality Committee for review and recommendation to change in frequency based upon findings. A new Resident Care Coordinator is in place and was educated on 9/3 and 9/4 regarding updating assessments.</p>				

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	<p>On 8-2-14 at 9:30 A.M., a review of a form titled "Short Term Monitor/Change of Condition Report" indicated the resident was re-admitted to the facility on 6-6-14 from a Long Term Care Facility. The form indicated the resident was re-oriented to call light, resident to use call light for assistance and keep walker with resident at all times.</p> <p>On 8-21-14 at 9:45 A.M., the Resident Service Notes dated 6-6-14 indicated "...Resident came back from [name of Long Term Care Facility] with new ordered [sic] and L [left] heel wound...." The Resident Service Notes from 6-7-14 thru 8-1-14 did not contain measurements or observations of a wound. A Nursing Comprehensive Evaluation dated 6-22-14 indicated Resident #5 had an open wound to LLE (left lower extremity) and the Home Health Care nurse assessed and dressed the wound. A Resident Service Note dated 8-4-14 indicated the resident had an "ulcer to the anterior left mid shin" The ulcer measured 4.0 c.m. (centimeters) by 3.0 c.m. by 1.0 c.m. There was no signs of infection, the wound bed was red, with granulation tissue present.</p> <p>On 8-21-14 at 10:24 A.M., the Administrator provide a policy titled</p>			

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	<p>"Service Assessment Interpretive Guidelines", dated 1/2007 and indicated the policy was the one currently used by the facility for assessments. The policy indicated "...Change of condition re-assessments are indicated any time there is a significant change in condition that will result in a change in care needs for a period of time longer than 14 days. Services needed for less than 14 days should be handled through changes on the MAR (Medication Administration Record) and instructions on the task sheets and the Short-Term Health Monitoring/Change of Condition Tool.</p> <p>During an interview on 8-21-14 at 2:15 P.M., the Director of Nursing (DON) indicated the facility had an order from the resident's physician for a home health nurse to see the resident 3 times a week to assess the wound, apply medication ordered by the physician and to dress the wound. The DON further indicated the facility's nurses should of assessed the wound thoroughly, with documentation that included measurements and locations of each wound the resident had at the time of the re-admission. A policy regarding the use of a Home Health Agency, in the facility, was requested but never received.</p>						

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

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