

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2014
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00146261.</p> <p>Complaint IN00146261 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314, F323, F508, and F514.</p> <p>Survey dates: March 26, 27, and 28, 2014</p> <p>Facility number: 000013 Provider number: 155038 AIM number: 100266100</p> <p>Survey team: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 62 SNF: 5 Total: 67</p> <p>Census payor type: Medicare: 8 Medicaid: 58 Other: 1 Total: 67</p> <p>Sample: 6</p> <p>These deficiencies also reflect state</p>	F000000	<p>"This Plan of Correction consitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiencies or conclusions contained in the Department's inspection report."We respectfully request that your office will accept this plan as our facility's compliance and that you consider a desk reivew as the tags cited are not deemed to be actual harm or immediate jeapordy. Please review our attachments with the cited defienicies as an audit tool.If you ahve any questions, please contact me at (765)289-3341. Thank you in advance for your immediate attention in this matter.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiencystatement ending with an asterisk (*) denotes a defecency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			
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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions identified in a resident's plan of care were in place to prevent possible skin breakdown for 1 of 3 resident's reviewed for prevention of pressure areas in a sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>1.) During observations on the following dates and times, Resident #B was up in her Foam Geri-chair with short sleeves on and no skin or elbow protectors on her elbows and/or arms:</p> <p>3/26/14 at 1:15 p.m. and 3 p.m.</p> <p>3/27/14 at 9:20 a.m., 10:55 a.m., 12:40 p.m., 1:40 p.m., 2:55 p.m., and 4 p.m.</p>	F000314	<p>Resident B:A skin assessment has been completed on this resident, no areas of breakdown or pressure areas were identified. An IDT review of the residents plan of care and interventions was completed. Care plans have been updated to reflect the resident's current status.The facility has completed an 100% audit of current resident populaiton to include reievew of the braden scale, physician's orders, care plans, TAR"s, and CNA assignment sheets. Re-education has been completed for prevention of pressure ulcers and ensuring preventative measures are in place as per the care plan.It is the responsibility of nursing staff to ensure preventative measures are in place as care planned. The Licensed Supervisory Nurse/designess will be responsible to conduct walking rounds 1 time per shift daily for 30 days, twice daily for 30 days, and</p>	04/27/2014			

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	<p>3/28/14 at 9:20 a.m.</p> <p>The resident was having involuntary spastic movements of her arms and legs against the foam covering. She was wearing soft "footies" on her feet during all of the observations, but her elbows were not covered and were rubbing against the cloth covering of the foam chair.</p> <p>During an observation, conducted with LPN #1 on 3/28/14 at 11:15 a.m., Resident #B was up in her foam geri type chair. She was wearing short sleeves and was not wearing any elbow protectors or any type of protective skin covering. The resident's elbows were observed at this time. The elbows were slightly pink in color, but her skin was intact. LPN #1 indicated the resident should have geri sleeves or elbow protectors on her elbows. She indicated she knew the resident had worn them in the past.</p> <p>The clinical record for Resident #B was reviewed on 3/27/14 at 1:45 p.m. Diagnoses for the resident included, but were not limited to, Huntington's Chorea, muscle spasticity, and dementia.</p>		<p>then weekly for 12 weeks. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The DON/Designee will be responsible to review the audits completed daily/weekly. Results of the reviews will be forwarded to the Quality Performance Improvement Committe for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.</p>		

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	<p>An annual Minimum Data Set (MDS) assessment, dated 2/20/14, indicated the resident was moderately cognitively impaired and required the assistance of the staff for mobility, bathing, and dressing. The MDS indicated the resident was at risk for skin breakdown.</p> <p>A "Skin Integrity Assessment: Prevention and Treatment Plan of Care" for Resident #B indicated the resident had a Braden scale (a scale that determines pressure ulcer risk) completed and was at moderate risk for the development of pressure ulcers. The plan of care also indicated the resident was at risk for scratches, abrasions/injury due to Huntington's chorea with spastic movements. One of the approaches for both of these problems was to manage friction and shear by protecting elbows and heels if being exposed to friction.</p> <p>Review of the CNA assignment sheet for Resident #B, provided by the DoN on 3/28/14 at 1 p.m., included, but was not limited to: "At risk"- "falls, skin." Under the section for additional information was "Elbow protectors".</p> <p>Review of the current facility policy, revised April 2009, provided by the</p>			

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	<p>Education Director on 3/28/14 at 12:50 p.m., titled "Pressure Ulcer Prevention/Treatment", included, but was not limited to, the following:</p> <p>"Policy</p> <p>...Moderate Risk (13-14)</p> <p>...Manage moisture, nutrition and friction and shear...."</p> <p>Procedure</p> <p>...d. Manage Friction and Shear</p> <p>...Protect elbows and heels if being exposed to friction...."</p> <p>This federal tag relates to Complaint IN00146261.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure interventions to help prevent falls and/or injury from falls were in place as identified in each resident's plan of care for 2 of 3 residents reviewed with a history of falls in a sample of 6. (Resident #D and #G)</p> <p>Findings include:</p> <p>1.) During an observation on 3/26/14 at 1:20 p.m., Resident #D was lying on his low bed on his right side facing the wall. A cushioned mat was next to the resident's bed. The resident's call light was at the foot of the bed on the floor and slightly under the edge of the bed. The call light was not within reach of the resident.</p> <p>During an observation on 3/27/14 at 9:30 a.m., the resident was in bed on his right side facing the wall. The cushioned mat was on the floor but was not adjacent to the bed. The mat was scooted away from the bed and the resident would have fallen</p>	F000323	Resident D has been reviewed by the IDT. The resident's care plans, physician's orders, and CNA Assignment sheets were updated. Resident D is able to have liquids. Resident G no longer resides at the center. A one time audit of current resident population has been completed for fall interventions, care plans, physician's orders, and CNA assignment sheets. Staff will be re-educated to the interventions in place for the residents identified at risk for falls. It is the responsibility of nursing staff to ensure preventative measures are in place as care planned. The Licensed Supervisory Nurse/designee will be responsible to conduct walking rounds 1 time per shift daily for 30 days, twice daily for 30 days, and then weekly for 12 weeks. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The DON/Designee will be responsible to review the audits completed daily/weekly. Results of the reviews will be forwarded to the Quality Performance Improvement	04/27/2014			

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	<p>onto the floor if he rolled out of the bed. The resident's call light was at the foot of the resident's bed and slightly under the bed. The call light was not within reach of the resident.</p> <p>When summoned to the room, on 3/27/14 at 9:35 a.m., the DoN indicated the mat should be next to the resident's bed and she picked up the mat and moved it next to the resident's bed. The DoN indicated the resident's call light was not within reach and she obtained the call light from the floor and placed it within reach of the resident.</p> <p>The clinical record for Resident #D was reviewed on 3/27/14 at 9:50 a.m. Diagnoses for Resident #D included, but were not limited to, schizophrenia, dementia, gastrostomy tube placement, malnutrition, and seizures.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/3/14, indicated the resident had cognitive impairment and required the assistance of the staff for transfers and toileting. The MDS indicated the resident had fallen once since admission.</p> <p>The nursing notes for Resident #D</p>		Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.		

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	<p>indicated the resident had a history of falls on 3/3/14, 3/7/14, 3/11/14, and 3/22/14.</p> <p>A Fall/Injury Risk health care plan, dated 2/26/14, indicated the resident was a risk for falls due to poor weight bearing, weakness, dementia, bowel and bladder incontinence, and mental status change. Approaches for the problem included, but were not limited to, "keep frequently used items in reach, (call light, i.e.)" and low bed with mat to floor.</p> <p>2.) During an observation on 3/26/14 at 1:25 p.m., Resident #G was lying in bed. The head of the resident's bed was elevated. A mat was on the floor by the resident's bed. The top of the mat was half way under the bed and the bottom of the mat was over half way under the bed with the bottom right wheel of the bed on the middle of the mat. The mat was observed in this same manner on 3/26/14 at 3:18 p.m.</p> <p>During an observation on 3/27/14 at 9:35 a.m., the resident was lying in bed. The mat was next to the resident's bed, but was in the same manner as observed the previous day. The mat was still half under the resident's bed with the bottom right</p>			
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	<p>wheel of the bed sitting on the mat. The resident's upper body would have most likely have made contact with the floor instead of the mat had she attempted to get out of bed or rolled out of bed.</p> <p>When summoned to the room on 3/27/14 at 9:40 a.m., the DoN indicated the mat was too far under the bed and should be moved out and adjacent to the bed. The Assistant DoN entered the room at this time and lifted the lower end of the bed off of the mat so the DoN could move it into place adjacent to and aligned with the bed.</p> <p>The clinical record for Resident #G was reviewed on 3/27/14 at 12:55 p.m. Diagnoses for the resident included, but were not limited to, traumatic brain injury, dementia with behaviors, and bipolar disorder.</p> <p>An re-admission Minimum Data Set (MDS) assessment, dated 3/3/14, indicated the resident had problems with both short and long term memory and required the assistance of the staff for transfers and toileting. The MDS indicated the resident had fallen twice since 12/12/13.</p> <p>The nursing notes for Resident #G</p>			
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	<p>indicated the resident had fallen from her bed to a mat on the floor on 3/23/14 at 3:30 p.m. The note indicated the resident's head was off of the mat and was resting on the linoleum floor.</p> <p>A Fall/Injury Risk health care plan, dated 3/5/14, indicated the resident was a risk for falls due to multiple risk factors including dementia and traumatic brain injury. Approaches for the problem included, but were not limited to, the placement of a matt on the floor next to the resident's bed.</p> <p>3.) Review of the current facility policy, revised November 2013, provided by the Education Director on 3/28/14 at 12:50 p.m., titled "Fall/Injury Assessment: Prevention and Management Care Plan", included, but was not limited to, the following:</p> <p>"Policy: Extendicare Health Services, Inc. (EHSI) revised the residents Care Plan and/or center practices to reduce the likelihood of another fall. Determining casual factors leading to a resident fall is necessary to provide consistent interventions to help prevent future occurrences....</p> <p>Procedure</p>			
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	<p>1. Assess risk factors and hazards to identify interventions that reduce the risk of fall/injury....</p> <p>3. Determine appropriate interventions for identified risk factors....</p> <p>Implement interventions to reduce risk in residents with confusion...."</p> <p>This federal tag relates to Complaint IN00146261.</p> <p>3.1-45(a)(2)</p>			
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F000508 SS=D	<p>483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure arrangements for a "swallow study" were made in a timely manner for 1 of 1 resident reviewed with physician's orders for a "swallow study" in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 3/27/14 at 9:50 a.m. Diagnoses for Resident #D included, but were not limited to, schizophrenia, dementia, gastrostomy tube placement, malnutrition, and seizures.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/3/14, indicated the resident had cognitive impairment and required the assistance of the staff for all activities of daily living. The MDS indicated the resident received nutritional feedings via a gastrostomy tube.</p>	F000508	Resident D Swallow study completed 3/31/14. A one time audit of current resident population has been completed for tests/orders that require staff to schedule for completion. Staff have been provided re-education regarding the timeliness and follow-up and tests and orders. It is the responsibility of Nursing and Social Services staff to ensure appointments, tests/orders are scheduled and completed as per MD order. The DON/Designee will be responsible to ensure new orders for test/orders have been scheduled by staff daily, Monday thru Friday, for 6 weeks, and then weekly for 18 weeks. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed daily/weekly. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI	04/27/2014

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	<p>An admission nursing note, dated 2/25/14 at 8:25 p.m., indicated the resident had a gastrostomy tube and was not allowed anything by mouth due to an absent gag reflex. The note indicated the resident was requesting a "Pepsi."</p> <p>A physician's order, dated 3/7/14, indicated "Speech Therapy clarification: Recommend resident to have modified barium swallow study and treatment at hospital with speech therapist and radiologist present. Dx [diagnoses] of dysphagia/oropharyngeal."</p> <p>The nursing notes from 3/7/14 through 3/18/14 lacked any information related to the arrangements for the swallow study having been made.</p> <p>A nursing note, dated 3/19/14 at 3:20 p.m., indicated "Res [resident] scheduled for Modified Barium Swallow Study March 31st at 8:20 a.m...."</p> <p>The Don and Administrator were interviewed on 3/27/14 at 1:35 p.m. Additional information was requested related to the swallow study having been ordered on 3/7/14 and no documentation of it having been</p>		committee.	

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	<p>scheduled until the nursing note on 3/19/14 at 3:20 p.m. This indicated a time period of 12 days from the date the order was received until the test was scheduled.</p> <p>The DoN was interviewed on 3/27/14 at 2:20 p.m. She indicated she had checked the calendar on the unit and it indicated the staff had called about the test on 3/10/14 and the hospital did not get back with them until 3/19/14. She indicated the information on the calendar was not part of the clinical record.</p> <p>The clinical record lacked any entries dated 3/10/14 related to the staff having called the local hospital to request a swallow study be scheduled for Resident #D. The nursing notes lacked any entries related to the staff attempting to follow up on the lack of return contact regarding the request for a swallow study for Resident #D.</p> <p>The facility Speech Therapist #1 was interviewed on 3/27/14 at 10:00 a.m. She indicated she was contracted staff and had just started at the facility on 3/17/14. She indicated she went through her speech therapy records shortly after she was hired and had discovered the 3/7/14 order</p>			

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	<p>for Resident #D to have a swallow study. She indicated she did not see where the test had been scheduled or completed and had notified the nursing staff of the need to schedule the test. She indicated she was working with the resident and was aware now that the test had been scheduled for 3/31/14.</p> <p>During an interview with a Speech Therapist (Speech Therapist #2) at the local hospital on 3/28/14 at 3:20 p.m., she indicated the following:</p> <p>She had the unit secretary check voice mails back to 3/10/14 and the unit had no record of any calls being made to them from the facility regarding the need for a swallow study for the resident until 3/19/14. She indicated the facility contacted the hospital on 3/19/14 and a request was made for the swallow study to be scheduled. The hospital staff requested a copy of the order for the swallow study. She indicated a physician's order, dated 3/7/14, for a swallow study for Resident #D was faxed to them on 3/19/14 and the test was then scheduled for 3/31/14.</p> <p>This indicated a 12 day time period from the date the test was ordered and the hospital was contacted</p>			
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	<p>requesting the test be scheduled.</p> <p>This federal tag relates to Complaint IN00146261.</p> <p>3.1-49(g)</p>			
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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented for 1 of 3 residents reviewed for complete and accurate clinical record documentation in a sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 3/27/14 at 9:50 a.m. Diagnoses for Resident #D included, but were not limited to, schizophrenia, dementia, gastrostomy tube placement, malnutrition, and seizures.</p> <p>A physician's order, dated 3/7/14, indicated "Speech Therapy</p>	F000514	Resident D's swallow study has been completed. A one time audit has been completed for current resident population to ensure documentation is complete and accurate. Re-education has been completed for staff on ensuring the the medical record is complete and accurate, and completing documentation timely. It is the responsibility of each department to ensure documentation has been completed timely. The IDT/designee will be responsible to review documentation of 10% resident population daily for 30 days, and then weekly for 20 weeks. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed daily/weekly.	04/27/2014			

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	<p>clarification: Recommend resident to have modified barium swallow study and treatment at hospital with speech therapist and radiologist present. Dx [diagnoses] of dysphagia/oropharyngeal."</p> <p>The nursing notes from 3/7/14 through 3/18/14 lacked any information related to the arrangements for the swallow study having been made.</p> <p>A nursing note, dated 3/19/14 at 3:20 p.m., indicated "Res [resident] scheduled for Modified Barium Swallow Study March 31st at 8:20 a.m...."</p> <p>The Don and Administrator were interviewed on 3/27/14 at 1:35 p.m. Additional information was requested related to the swallow study having been ordered on 3/7/14 and no documentation of it having been scheduled until the nursing note on 3/19/14 at 3:20 p.m.</p> <p>The DoN was interviewed on 3/27/14 at 2:20 p.m. She indicated she had checked the calendar on the unit and it indicated the staff had called to schedule the test on 3/10/14. She indicated the information on the calendar had not been documented</p>		Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.				

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	<p>in the resident's clinical record.</p> <p>The resident had a physician's order, dated 3/14/14, which indicated the resident could have water from a sippy cup orally. The resident had previously been NPO (nothing by mouth). The clinical record lacked any information, dated 3/14/14, related to the how the resident was able to tolerate the water from the sippy cup.</p> <p>The resident had a physician's order, dated 3/21/14 at 11 a.m., which indicated the resident could now receive a regular diet with ground meat and nectar thickened liquids. The clinical record lacked any information, dated 3/21/14, related to how the resident tolerated the new diet for the lunch or supper meal.</p> <p>The DoN was interviewed on 3/28/14 at 11:45 a.m. Information was requested related to whether any water was given to the resident on 3/14/14 and how he had tolerated the new order for water orally. Information was also requested related to how the resident tolerated the diet change order on 3/21/14.</p> <p>The DoN was interviewed on 3/28/14 at 1:30 p.m., the DoN indicated she</p>			
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	<p>had given the resident water from a "blue lid control cup" on 3/14/14 after the order was received and he drank without difficulty. She indicated she had failed to document this in the resident's clinical record, but would now make a late entry. The DoN indicated she had talked to the second shift nurse who worked on 3/21/14 and the nurse stated the resident had taken the food very well for supper that night and had not had any problems. The DoN indicated the nurse had not documented the observation of the resident's food and fluid intake related to the new diet order in the clinical record.</p> <p>Review of the current facility policy, revised July 2012, provided by the Education Director on 3/28/14 at 12:50 p.m., titled "Episodic Documentation", included, but was not limited to, the following:</p> <p>"Policy</p> <p>Extendicare Health Services, Inc. (EHSI) centers will document significant resident care issues each shift until stabilized or the situation is otherwise resolved....</p> <p>Procedure</p>						

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	<p>1. Enter the date and time of occurrence.</p> <p>2. Document the facts regarding the care issue or incident as applicable, including, but not limited to:</p> <p>...Physical assessment Resident response...."</p> <p>This federal tag relates to Complaint IN00146261.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			
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