

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2016
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NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 19, 20, 21, 22, 25, 26, 27, and 28, 2016.</p> <p>Facility number: 000514 Provider number: 155503 AIM number: 100266800</p> <p>Census bed type: SNF/NF: 85 Residential: 14 Total: 99</p> <p>Census payor type: Medicare: 8 Medicaid: 59 Other: 18 Total: 85</p> <p>These deficiencies reflect State findings cited in accordance with the 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on August 05, 2016.</p>	F 0000		

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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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a care plan was developed for a resident on an anti-platelet medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #118)</p> <p>Findings include:</p> <p>On 7/22/16 at 2:50 p.m., Resident #118's clinical record was reviewed. Diagnoses</p>	F 0279	-This plan of correction constitutes Exceptional Living Center of Brazil's written allegation of compliance for the deficiencies cited during the annual survey conducted July 19 through July 28, 2016. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted	08/27/2016

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	<p>included but were not limited to: heart failure, edema (swelling), and hypertension (high blood pressure).</p> <p>Resident #118's July 2015, physician's orders included the following:</p> <p>On 3/1/16 (start date), the resident was ordered Eliquis (anti-platelet medication) 2.5 milligrams twice a day.</p> <p>Resident 118's clinical record lacked documentation of a care plan related to the medication Eliquis.</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 34th edition, copyright 2015, Nursing Consideration Alert for Eliquis included: "Promptly evaluate signs and symptoms of blood loss. Drug can cause serious, potentially fatal bleeding."</p> <p>On 7/25/16 at 12:27 p.m., the MDS (Minimum Data Set) Coordinator indicated if a resident was taking an anti-platelet medication such as Eliquis, a care plan should have been developed.</p> <p>7/26/16 at 9:47 a.m., the Director of Nursing indicated Resident #118 did not have a care plan related to Eliquis and a care plan was created yesterday, on 7/25/16. She further indicated she missed creating the care plan, however she was</p>		<p>to meet state and federal requirements. The Exceptional Living Center of Brazil respectfully requests consideration of this Plan of Correction for paper compliance.</p> <p>Plan of Compliance Date: 08/27/2016</p> <p>F279 Develop Comprehensive Care Plans</p> <ol style="list-style-type: none"> Resident #118 -Resident's care plans were reviewed and updated to accurately reflect the use of an anti-platelet medication. All residents receiving an anti-platelet medication have the potential to be affected. The care plans for all residents that receive an anti-platelet medication were reviewed for accuracy and updated as needed. (See Attachment A) The Interdisciplinary Team and all licensed nurses will be re-educated regarding the implementation of care plans for residents receiving anti-platelet medications. (See attachemnt B) An audit of anti-platelet care plans will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further recommendations. (See 	

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F 0309 SS=D Bldg. 00	<p>told she could back date the care plan to the resident's admission date of 3/1/16.</p> <p>On 7/26/16 at 9:32 a.m., the Executive Director provided the facility policy, "Care Plan," effective date 4/1/12, and indicated it was the policy currently being used. The policy indicated, ".... 2. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems ..."</p> <p>3.1-35(a)</p> <p>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. Based on observation, interview, and record review, the facility failed to document a fall and implement follow-up assessments as indicated by facility policy for a resident observed lying on a mat on the floor after being on the edge</p>			F 0309	<p>attachment A) 5. Date of compliance: 08/27/2016</p> <p>F309 <u>Provide Care/Services for Highest Well Being</u> 1. Resident #104 was assessed and no issues were identified. (See Attachemnet C) 2. All residents who</p>		08/27/2016

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	<p>of the bed for 1 of 5 residents reviewed for accidents. (Resident #104).</p> <p>Findings include:</p> <p>On 7/22/2016 at 2:00 p.m., Resident #104 was observed to be on the edge of the bed in a fetal position and crying. The facility staff was immediately notified that Resident #104 was on the edge of the bed. When facility staff arrived, Resident #104 was observed lying on a mat on the floor with the left side of her face against the mat and in a fetal position. The bed was in low position and a body pillow was lying on the floor next to the resident.</p> <p>The clinical record was reviewed for Resident #104 at 7/25/2016 at 10:24 a.m. Diagnoses included, but were not limited to dementia and fracture of the right fibula (lower leg bone).</p> <p>The clinical record lacked documentation from 7/22/2016, which indicated Resident #104 had been found on the mat after being in the bed or that an assessment had been completed after the incident occurred.</p> <p>During an interview on 7/26/2016 at 10:47 a.m., License Practical Nurse (LPN) #2 indicated she did not consider</p>				<p>require documentation after a fall and follow up assessments have the potential to be affected. An audit was completed to identify residents that have had a fall in the last 30 days and care plans have been updated as needed. (Se attachment D)</p> <p>3. All licensed nurses will be re-educated on Falls Management, including documentation and follow up assessments. (See attachment B).</p> <p>4. An audit of fall documentation and assessments will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further recommendations. (See attachment D)</p> <p>5. Date of compliance: 08/27/2016</p>		

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	<p>the incident on 7/22/2016 at 2:00 p.m., for Resident #104 a fall because the resident frequently scoots herself to the end of the bed then falls to the mat and she is care planned for this behavior.</p> <p>During an interview with the Administrator on 7/26/2016 at 10:48 a.m., she indicated the facility always charts after an incident of a fall, but they did not consider Resident #104 to have a fall due to being care planned for scooting. The clinical record for Resident #104 lacked documentation of the incident and that an assessment was completed, because Resident #104 frequently scoots to the edge of the bed and falls to the mat.</p> <p>During an interview on 7/26/2016 at 2:47 p.m., with the Corporate Nurse and the Director of Nursing (DON), the Corporate Nurse indicated the nurse on duty did complete an assessment on Resident #104 for the incident on 7/22/2016 at 2:00 p.m., but for some reason did not document it. The nurse had been educated on what she needs to do as far as documenting the assessment and will be making a late entry.</p> <p>The current care plan with a last reviewed/revised date of 7/26/2016, for Resident #104 indicated, " ...Problem:</p>			

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F 0329 SS=D Bldg. 00	<p>Resident places self on floor bedside bed [sic] ... Goal: Resident will be free of injuries by placing self on floor by mat ... Approach: 2. Monitor if noted resident is on floor check for injuries and document any injuries noted ..."</p> <p>On 7/25/2016 at 3:30 p.m., the Administrator provided the facility's policy, "Fall Management," dated 3/16/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "Definition of a Fall: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface [e.g. onto a bed, chair or a bedside mat] ... Evaluate and monitor the resident for 72 hours post fall ..."</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for</p>			

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	<p>excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure residents who received a psychotropic medication were monitored for targeted behaviors for 1 of 5 residents reviewed for unnecessary medication use (Resident #137).</p> <p>Findings include:</p> <p>On 7/25/16 at 2:20 p.m., Resident #137's clinical record was reviewed. Diagnoses included but were not limited to: dementia, anxiety, and depression.</p> <p>The physician's July 2016, orders for Resident #137 indicated the following:</p> <p>On 7/6/16 (start date) the resident was ordered Lexapro (an antidepressant</p>	F 0329	<p>F329 <u>Drug Regimen is free from Unnecessary Drugs</u></p> <p>1. Target behavior monitoring has been implemented for the use of a psychotropic medication for Resident #137. (Attachment E)</p> <p>2. All residents receiving psychotropic medications have the potential to be affected. An audit was completed to identify residents receiving psychotropic medications and target behavior monitoring was implemented as needed. (See attachment F)</p> <p>3. All licensed nurses and the Interdisciplinary Team will be re-educated regarding initiation of target behavior monitoring for residents receiving psychotropic medication. (See attachemtn G)</p> <p>4. An audit of target</p>	08/27/2016

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	<p>medication) 20 milligrams daily.</p> <p>On 7/9/16 (start date) the resident was ordered lorazepam (an antianxiety medication) 0.5 milligrams twice a day.</p> <p>The clinical record lacked documentation which indicated targeted behaviors for which the medications were prescribed were monitored for Resident #137's Lexapro and lorazepam.</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, Black Box Warning for Lexapro included: "... Monitor patient closely for worsening of depression or suicidal behavior..."</p> <p>On 7/26/16 at 10:39 a.m., RN #1 indicated the order for Resident #137's targeted behavior monitoring did not begin until 7/25/16.</p> <p>On 7/26/16 at 3:14 p.m., the Director of Nursing indicated the behavior monitoring should have began at admission for Resident #137.</p> <p>On 7/26/16 at 9:32 a.m., the Executive Director provided the facility policy, "Behavior Monitoring," dated June 1, 2015, and indicated it was the policy currently being used. The policy</p>		<p>behavior monitoring for residents receiving psychotropic medication will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further recommendations.(See attachment F)</p> <p>5. Date of compliance 08/27/2016</p>	

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F 0371 SS=E Bldg. 00	<p>indicated, "... The licensed nurse is responsible to initiate the Target Behavior/ Behavior FlowSheets to monitor residents [sic] individual Target Behaviors related to Psychotropic med use, as indicated by the patient behavior and/or for patients receiving a psychotherapeutic medication ... Behaviors will be documented each shift by indicating the Frequency ... and Intensity ..."</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff utilized unexpired chemical testing strips for testing of the manual dishwashing sanitation sink for 1 of 1 kitchen.</p> <p>Findings include:</p>	F 0371	<p>F371 Food Procure, Store/Prepare/Serve-Sanitary</p> <p>1. The chemical testing strips utilized for testing of the manual dishwashing sink were immediately disposed of and replaced with new strips.</p> <p>2. All residents have the potential to be affected. Residents were assessed to determine any</p>	08/27/2016

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	<p>On 7/25/2016 at 10:45 a.m., the Dietary Manager (DM) was observed to test the chemical quality of the manual dishwashing sanitation sink with a chemical testing strip. The container of chemical testing strips was observed to have an expiration date of 1/1/2013. The DM indicated the testing strips never expire and she had never noticed an expiration date being on the test strip.</p> <p>On 7/25/2016 at 2:20 p.m., an interview with a staff member at the chemical strip manufacturing office indicated the strips would not be accurate and should be replaced since they expired in 2013.</p> <p>On 7/25/2016 at 11:19 a.m., the DM provided the facility policy, "Cleaning Dishes - Manual Dishwashing," dated 3/17/2016, and indicated it was the one currently being used by the facility. The policy indicated, ..."2. Test the sanitizing solution in the sink using the manufacturer's suggested test strips to assure appropriate level ..." The policy did not address the expiration date on the chemical test strips.</p> <p>3.1-21(i)(3)</p>		<p>adverse affects related to the alleged deficiency. No concerns were identified.</p> <p>3. The Dietary Manager and all Dietary staff will be re-educated on facility's policy and procedure for Cleaning Dishes-Manual Dishwashing.(See attachment H)</p> <p>4. An audit to ensure unexpired chemical testing strips are utilized for testing of the manual dishwashing sanitation sink will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further recommendations. (See attachment I)</p> <p>5. Date of compliance 08/27/2016</p>	

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F 0465 SS=D Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary room environment for 1 of 35 resident rooms observed for environmental conditions during stage 2. (Resident #69)</p> <p>Findings include:</p> <p>On 7/20/16 at 1:33 P.M., a smeared brown substance was observed on the wall by the call light cord in the room of Resident #69.</p> <p>On 7/22/16 at 2:30 P.M., the smeared brown substance was observed on the wall in the same location in the room of Resident #69.</p> <p>On 7/26/16 at 12:10 P.M., the smeared brown substance was observed on the wall in the same location in the room of Resident #69.</p>	F 0465	<p>F465 <u>Safe/Functional/Sanitary/Comfortable Environment</u></p> <ol style="list-style-type: none"> 1. The room of resident #69 was deep cleaned and the smeared brown substance on the wall was removed. 2. All residents have the potential to be affected. An audit of all residents rooms was completed and no issues were identified. 3. All staff will be re-educated on maintaining a sanitary room environment. A cleaning schedule to systematically clean and perform needed observations/inspections will be developed to maintain a sanitary room environment. 4. An audit of resident rooms will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further 	08/27/2016

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	<p>During a clinical record review on 7/26/16 at 12:30 P.M., a progress note dated 7/5/16, indicated the resident had an ostomy (surgically created opening in the body for the discharge of body wastes) on the RLQ (right lower quadrant of the abdomen) and at times the resident takes the ostomy bag off due to confusion as to its purpose.</p> <p>A behavior monitoring record dated 7/13/16 through 7/26/16, indicated the resident had a target behavior of removing the colostomy clip and getting BM (bowel movement) everywhere. The behavior monitoring note indicated this behavior occurred one time on 7/20/16, and one time on 7/24/16.</p> <p>During an interview on 7/26/16 at 2:00 P.M., CNA (Certified Nursing Aid) #1 observed the brown smeared substance on the wall in the room of Resident #69 and indicated the resident often removed his ostomy bag and the stool from the bag ends up in various places and requires cleanup. She indicated this has been an ongoing issue regarding the resident and the smears on the wall were likely excrement and should have been cleaned before now.</p> <p>During an interview on 7/26/16 at 2:25</p>		<p>recommendations. (See attachment J) 5. Date of compliance: 08/27/2016</p>				

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F 0514 SS=D Bldg. 00	<p>P.M., Housekeeper #1 indicated that each resident room in the facility is cleaned on a daily basis. This includes bathroom cleaning, trash removal, floor sweeping and mopping, and general inspection of the room including walls for anything that is in need of cleaning.</p> <p>3.1-19 (f)</p> <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</p>				

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	<p>the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to document a fall and implement follow-up assessments as indicated by facility policy for a resident observed lying on a mat on the floor after being on the edge of the bed for 1 of 5 residents reviewed for accidents. (Resident #104).</p> <p>Findings include:</p> <p>On 7/22/2016 at 2:00 p.m., Resident #104 was observed to be on the edge of the bed in a fetal position and crying. The facility staff was immediately notified that Resident #104 was on the edge of the bed. When facility staff arrived, Resident #104 was observed lying on a mat on the floor with the left side of her face against the mat and in a fetal position. The bed was in low position and a body pillow was lying on the floor next to the resident.</p> <p>The clinical record was reviewed for Resident #104 at 7/25/2016 at 10:24 a.m. Diagnoses included, but were not limited to dementia and fracture of the right fibula (lower leg bone).</p> <p>The clinical record lacked documentation from 7/22/2016, which indicated Resident #104 had been found on the mat</p>	F 0514	<p>F514 <u>Records-Completed-Accurate-Accessible</u></p> <ol style="list-style-type: none"> 1. Resident #104 was assessed and no issues were identified. 2. All residents who require documentation after a fall and follow up assessments have the potential to be affected. An audit was completed to identify residents that have had a fall in the last 30 days. Documentation has been reviewed and care plans have been updated as needed. (Se attachment D) 3. All licensed nurses will be re-educated on Falls Management, including documentation and follow up assessments. (See attachment B). 4. An audit of fall documentation and assessments will be completed 3 times a week for 4 weeks, one time a week for 4 weeks, then monthly for 6 months. The results of the audits will be submitted and reviewed monthly by the Quality Assurance Committee for further recommendations. (See attachment D) 5. Date of compliance: 08/27/2016 	08/27/2016			

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	<p>after being in the bed or that an assessment had been completed after the incident occurred.</p> <p>During an interview on 7/26/2016 at 10:47 a.m., License Practical Nurse (LPN) #2 indicated she did not consider the incident on 7/22/2016 at 2:00 p.m., for Resident #104 a fall because the resident frequently scoots herself to the end of the bed then falls to the mat and she is care planned for this behavior.</p> <p>During an interview with the Administrator on 7/26/2016 at 10:48 a.m., she indicated the facility always charts after an incident of a fall, but they did not consider Resident #104 to have a fall due to being care planned for scooting. The clinical record for Resident #104 lacked documentation of the incident and that an assessment was completed, because Resident #104 frequently scoots to the edge of the bed and falls to the mat.</p> <p>During an interview on 7/26/2016 at 2:47 p.m., with the Corporate Nurse and the Director of Nursing (DON), the Corporate Nurse indicated the nurse on duty did complete an assessment on Resident #104 for the incident on 7/22/2016 at 2:00 p.m., but for some reason did not document it. The nurse</p>			

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	<p>had been educated on what she needs to do as far as documenting the assessment and will be making a late entry.</p> <p>The current care plan with last reviewed/revised date of 7/26/2016, for Resident #104 indicated, " ...Problem: Resident places self on floor bedside bed [sic] ... Goal: Resident will be free of injuries by placing self on floor by mat ... Approach: 2. Monitor if noted resident is on floor check for injuries and document any injuries noted ..."</p> <p>On 7/25/2016 at 3:30 p.m., the Administrator provided the facility's policy, "Fall Management," dated 3/16/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "Definition of a Fall: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface [e.g. onto a bed, chair or a bedside mat] ... Evaluate and monitor the resident for 72 hours post fall ..."</p> <p>3.1-50(a)(2)</p>			

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 14</p> <p>Sample: 7</p> <p>Exceptional Living Center of Brazil was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Q.R. completed by 14466 on August 05, 2016.</p>	R 0000		