STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 / B. WING	05/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GROVE REHABILITATION CENTER	4255 MEDWELL DR NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00173064. Complaint IN00173064 - Substantiated, Federal/State deficiencies related to the allegations are cited at F314, F315, F328, and F469. Survey dates: May 12 and 13, 2015 Facility number: 000173 Provider number: 155273 AIM number: 100290920 Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 8 Medicaid: 43 Other: 26 Total: 77 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency 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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F 314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident's pressure ulcer dressing was changed and/or reinforced, for 1 of 3 residents reviewed with pressure ulcers, in a sample of 3. Resident B Findings include: The clinical record of Resident B was reviewed on 5/12/15 at 1:20 P.M. Diagnoses included, but were not limited to, open wound of buttock. A quarterly Minimum Data Set (MDS) assessment, dated 4/7/15, indicated the resident scored a 15 out of 15 for cognition, indicating no memory	F 314	F314 1. Resident B's orders were clarified for the treatment of his coccyx wound. 2. Treatment orders for other residents with wounds have been reviewed and are appropriate. 3. Licensed nurses have been retrained on center policy for wound treatment and ensuring treatment orders are clear. 4. DON or designee will review all new treatment orders 5 xs per week on going to ensure orders have specific directions. Clarification to orders will be requested as needed. Identified non compliance with staff nurses transcribing orders will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in the center monthly QAPI meeting times 6 months and quarterly times 2 quarters to determine further recommendations as needed.	06/10/2015

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	impairment, required extensive assistance of two+ staff for bed mobility and personal hygiene, and had 1 unhealed pressure ulcer. A Care Plan, dated 4/30/15, indicated, "Areas of Impairment:...coccyx...Interventions: Provide treatment per MD order...." A wound care physician's order, dated 5/6/15, indicated, "Leave oil dressing in cocyxx [sic] ulcer in place. Do not remove. May change gauze dressing PRN [as needed]." An additional physician's order, dated 5/6/15, indicated, "May change Aquacel to superficial wounds on buttock. Apply zinc oxide to peri wound." On 5/12/15 at 2:25 P.M., RN # 1 indicated he was going to change Resident B's dressing. As he rolled the resident over, a large amount of old, dried, blackish drainage was observed on the draw sheet under the resident. When RN # 1 removed the protective mesh underwear holding the dressings, the dressings were all observed to be totally saturated with a dark greenish-grayish drainage. RN # 1 indicated at that time that he had not been there since 5/8/15, and had not seen the wound since then. RN # 1 indicated the dressings "could			

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	have been reinforced if needed." On 5/13/15 at 9:15 A.M., during an interview with RN # 2, she indicated that staff were to leave the dressing to the coccyx in place for 5 days. She indicated the oil dressing was inserted "deep into the wound." She indicated the resident always had a lot of drainage. She indicated she understood that the facility might have been too aggressive in trying to clear up the pressure ulcer, so that they were to "leave it alone." After reviewing the physician's order, RN # 2 indicated, "We probably need to clarify the order." On 5/13/15 at 3:05 P.M., the Administrator provided the current facility policy "Wound Prevention and Treatment," revised October 2014. The policy included: "...A resident with pressure ulcers will receive continued preventive interventions and necessary treatment and services to promote healing and prevent infection." This Federal tag relates to Complaint IN00173064. 3.1-40(a)(2)			

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F 315 SS=G Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to obtain an order for a foley catheter, document care for the catheter, discontinue the catheter when ordered, and provide	F 315	F 315 1. Resident A no longer resides in center. Resident B's catheter was cleaned and changed per center policy. 2. Residents with indwelling catheters have been assessed for	06/10/2015

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	catheter care, resulting in a resident's admission to the hospital with septic shock and hospital staff needing to reinsert a different foley catheter (Resident A); and failed to provide foley catheter care every shift as ordered (Resident B), for 2 of 3 residents sampled with foley catheters, in a sample of 3. Residents A and B Findings include: 1. The clinical record of Resident A was reviewed on 5/12/15 at 10:35 A.M. The resident was admitted to the facility on 3/20/15 with diagnoses including, but not limited to, diabetes mellitus and left below the knee amputation. Admission Physician orders for the foley catheter were not found in the clinical record. A Nursing Admission Assessment, dated 3/20/15, indicated, "Alert, Orientation: Person, Place, Time...Genitourinary: F/C [foley catheter]...." A "Catheter Plan of Care," dated 3/24/15, indicated, "Contributing Diagnoses impacting incontinence: [left blank], Devices: [left blank]...Interventions: Empty drainage bag q [every] shift and PRN [as needed], Maintain closed		signs and symptoms of UTI, catheters were changed per physician order and catheter care performed. Physician orders are in place for all catheters. 3. CNA's were retrained on catheter care and reporting any unusual appearance to the licensed nurse. Licensed nurses were retrained on center policy for catheter use. Identified non-compliance will result in 1:1re-education with repeat non-compliance resulting in disciplinary action per policy up to and including termination 4. The DON or designee will review records of new admission with catheters or residents with new orders for catheters to ensure physician orders are in place for use and care. The DON or designee will monitor catheter care on one resident five times weekly for 4 weeks then three times weekly times four weeks, then weekly thereafter on an ongoing basis to ensure continued compliance. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be presented to the center Quality Assurance and Performance Improvement monthly meeting times 6 months and quarterly times 2 quarters to determine further recommendations as needed.	

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	drainage system...Strive to keep residents catheter free of feces." An admission Minimum Data Set (MDS) assessment, dated 3/27/15, indicated Resident A scored a 15 out of 15 for cognition, indicating no memory impairment. The resident required extensive assistance of two + staff for bed mobility, transfer, and toilet use. The "Bladder and Bowel" section indicated: "Urinary continence - Not rated, resident had a catheter (indwelling or condom), urinary ostomy, or no urine output for the entire 7 days." A Physician's order, dated 4/1/15, indicated, "D/C [discontinue] Foley." Documentation that the foley catheter was d/c'd was not found in the clinical record. CNA documentation indicated the resident continued to have an "Indwelling Catheter" from 4/1/15-5/5/15. The last measured urine output was 5/5/15 at 6:52 A.M., and was documented as "100 cc." The May 2015 Physician orders did not include orders for a foley catheter. Documentation in the Nursing Progress Notes regarding the foley catheter was not found after 4/1/15.			

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	Documentation regarding the flushing or care of the foley catheter was not documented on the April 2015 or the May 2015 Treatment Administration Record (TAR). Nursing Progress Notes, dated 5/5/15 at 7:15 A.M., indicated, "[Resident A] c/o [complains of] SOB [shortness of breath], chest discomfort...Organized transport to [hospital]...." A hospital Emergency Department (ED) note, dated 5/15/15 at 8:10 A.M., indicated, "Pt [patient] arrives to the ED...with complaints of abdominal pain and chest pain...Pt requests to go to a different facility due to the way the pt has been treated and neglection [sic]." An ED note, dated 5/5/15 at 8:15 A.M., indicated, "Pt requests he does not go back to the facility of [name of facility] due to the treatment that he received there. Pt reports he felt neglected stating 'Workers said they would come back and never came back.'" An ED note, dated 5/5/15 at 8:20 A.M., indicated, "Foley was in place from [name of facility]. Site was not clean and was retaped on his leg several times. Foley had no insertion date and was			

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	removed by this RN and replaced with new foley per Dr." An ED note, dated 5/5/15 at 8:27 A.M., indicated, "[Name] from social work called and informed her of the patient's condition on arrival to the ED. Pt had foley and PICC and was not kept cleaned. Pt requested not to go back to [name of facility]...." A hospital ED physician note, dated 5/5/15, indicated, "...Patient with positive C.Difficile test last week. Has been on generous supply of antibiotics over the past couple of months related to diabetic wound infection...[Lab work] WBC 52.1 [normal range 4.1-10.9]...Final Impression: 1. Septic shock...." A hospital History and Physical, dated 5/5/15, indicated, "...Assessment/Plan: Severe sepsis with acute organ dysfunction...Condition is guarded...." On 5/12/15 at 9:45 A.M., during an interview with EMS staff # 1, he indicated he was called to the facility on 5/5/15 for Resident A's complaint of chest pain. He indicated he observed that the resident's catheter bag was empty, and had old dried sediment inside the catheter tubing. He indicated the resident told him, "Don't let me go back there."			

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	On 5/13/15 at 2:15 P.M., during an interview with the Administrator and Interim Director of Nursing (DON), the Administrator indicated the facility had become aware of concerns regarding Resident A's foley catheter the previous week and had retrained staff on correct foley catheter care. The Administrator indicated staff were also retrained on reporting any unusual appearance of the catheter and/or urine to the licensed nurse 2. On 5/12/15 at 8:55 A.M., during the initial tour, the Interim DON indicated Resident B had a foley catheter. On 5/12/15 at 9:40 A.M., the Administrator provided a list of residents, indicating those residents considered interviewable. Resident B was highlighted as being interviewable. On 5/12/15 at 1:20 P.M., the clinical record of Resident B was reviewed. A quarterly MDS assessment, dated 4/7/15, indicated the resident scored a 15 out of 15 for cognition, indicating no memory impairment. A Physician's order, dated 8/14/14 and on the current May 2015 orders, indicated, "Catheter care every shift."			

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	A "Catheter Plan of Care," dated 8/14/14, indicated: "Contributing Diagnoses impacting incontinence: Contamination of...pressure ulcer with urine which impedes healing, Incontinence that can not be managed with intermittent catheterization. Devices: Uretheral catheter. Interventions: Daily Indwelling Catheter Care...." Nursing Progress Notes, dated 5/10/15 at 2:00 P.M., indicated, "Resident c/o [complains of] penile pain at his catheter insertion site. Catheter noted to have 'build-up' around insertion site. Catheter changed...Will monitor." A Treatment Administration Record (TAR), dated May 2015, indicated: "Catheter care every shift." From 5/1/15-5/12/15, there were 8 shifts that were left blank, indicating the lack of care. On 5/12/15 at 2:00 P.M., Resident B was observed lying in bed, with a foley catheter drainage bag hanging from the bed frame. Resident B was interviewed at that time. Resident B indicated he thought the staff was supposed to clean around the insertion site of his catheter once a day, but that "sometimes it's every other day."			

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	On 5/13/15 at 9:50 A.M., during interview with QMA # 1, he indicated, "We make sure catheter care is done every shift. We either do it ourselves or make sure the CNAs did it." QMA # 1 indicated the nursing staff initials the treatment record, indicating the care was completed. On 5/13/15 at 9:55 A.M., during an interview with CNA # 2, she indicated the CNAs did the catheter care "every time" they provided care. On 5/13/15 at 3:05 P.M., the Administrator provided the current facility policy on "Indwelling Urinary Catheters," dated July 2012. The policy included: "...All residents with an indwelling catheter require a medical justification for the initiation and continuing need for catheter use. A comprehensive assessment includes underlying factors...and development of a plan for appropriate indications for continuing use of an indwelling catheter beyond 14 days...Residents admitted to the center with an indwelling catheter that was placed elsewhere need a provider order and medical justification for the catheter to remain in place...." The Administrator also provided at that time the facility procedure "Providing Catheter			

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	Care," undated, which she indicated was provided to the staff, to retrain the staff on correct catheter care. This Federal tag relates to Complaint IN00173064. 3.1-41(a)(1)			
F 328 SS=G Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;			

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	Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on observation, interview, and record review, the facility failed to change and flush a PICC (a type of intravenous, or IV) line as ordered by the physician, resulting in hospital staff being unable to use the line and needing to insert a new intravenous line to provide medication and fluids, including that for septic shock, for 1 of 2 residents sampled with IV medications, in a sample of 3. Resident A Findings include: 1. The clinical record of Resident A was reviewed on 5/12/15 at 10:35 A.M. The resident was admitted to the facility on 3/20/15 with diagnoses including, but not limited to, diabetes mellitus and left below the knee amputation. A Nursing Progress Note, dated 3/20/15 at 1:45 P.M., indicated, "[Right] SL [single lumen] PICC in place, drsg [dressing] [changed 3/17/15, CDI [clean, dry, intact]...." Physician orders, initially dated 3/23/15 and on the May 2015 orders, indicated, "Change PICC line [dressing] every 7	F 328	F328 1. Resident no longer resides in center. 2. No other residents in the center have peripheral lines. 3. Licensed staff have been retrained on the center policy for PICC line flushing and dressing changes and documentation thereof. 4. DON and/or designee is to review treatment administration records of those residents with PICC lines 5 times weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 6 months to ensure that all ordered treatments have been completed. DON or designee will verify by observation that dressings to PICC lines are changed per physician order. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reported to the center QAPI committee monthly for 6 months and quarterly times 2 quarters to determine further recommendations	06/10/2015

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	days and PRN [as needed]. Flush PICC line with 10 ml normal saline once a shift." An admission Minimum Data Set (MDS) assessment, dated 3/27/15, indicated Resident A scored a 15 out of 15 for cognition, indicating no memory impairment. The resident required extensive assistance of two + staff for bed mobility, transfer, and toilet use. Documentation indicated the resident received IV fluids on 4/1/15 and on 4/2/15 due to abnormal lab work. A Treatment Administration Record (TAR), dated April 2015, indicated the resident's PICC dressing was changed on 4/13/15. Boxes marked 4/20/15 and 4/27/15, were left blank, indicating the dressing was not changed on those dates. The May 2015 TAR had no documentation that the PICC dressing was changed. The April 2015 TAR and May 2015 TAR indicated, "Flush PICC line with 10 ml normal saline once a shift." There were no times or initials indicating the line was flushed. A care plan regarding the care of the PICC line was not found in the clinical			

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	record. Documentation indicated the resident was transferred to the hospital emergency department (ED) on 5/5/15 at 7:15 A.M., due to chest pain. A hospital Emergency Department (ED) note, dated 5/15/15 at 8:10 A.M., indicated, "Pt [patient] arrives to the ED...with complaints of abdominal pain and chest pain...Pt requests to go to a different facility due to the way the pt has been treated and neglection [sic]." An ED note, dated 5/5/15 at 8:15 A.M., indicated, "Pt requests he does not go back to the facility of [name of facility] due to the treatment that he received there. Pt reports he felt neglected stating 'Workers said they would come back and never came back.'" A hospital ED note, dated 5/5/15 at 8:15 A.M., indicated, "Pt [patient] has PICC line in place has not been checked since 4/13. PICC line wound not draw blood. IV consult order placed." An additional ED note, dated 5/15/15 at 8:27 A.M., indicated, "[Name] from social work called and informed her of the patients [sic] condition on arrival to the ED. Pt had foley and PICC and was			

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	not kept cleaned. Pt requested not to go back to [name of facility]...." The hospital ED notes indicated an IV was placed in the resident on 5/5/15 at 8:51 A.M. An hospital history and physical, dated 5/15/15, indicated, "...He was transferred to the emergency room and found to be in renal failure and having intense abdominal pain...found to be hypotensive his been [sic] given fluid bolus...Labs: WBC 52.1 [normal 4.1-10.9]...Assessment/Plan: Severe sepsis with acute organ dysfunction...He is getting fluids aggressively...Condition is guarded...." On 5/12/15 at 9:45 A.M., during an interview with EMT staff # 1, he indicated when arrived at the facility on 5/5/15 to transport the resident to the hospital, he noted that the resident's PICC dressing was dirty "with a lot of old dried blood under a Tegaderm dressing." He indicated it appeared that the PICC line had been pulled out slightly, and he didn't want to try and use it. He indicated he wanted to give Resident A some IV medication for his nausea, but that he didn't want to use the PICC line "due to the condition of it." He indicated the resident told him, "Don't let me go back			

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	there." On 5/13/15 at 2:15 P.M., during an interview with the Administrator and the Interim Director of Nursing (DON), the Administrator indicated they had identified the concern regarding Resident A's PICC line the following week, and had retrained staff on correct PICC line care, including dressing and flushing. On 5/13/15 at 3:05 P.M., the Administrator provided the current facility policy "Peripheral Catheter Flushing," revised July 1, 2012. The policy included: "To Be Performed By: Licensed nurses according to state law and facility policy. The nurse shall be competent in the safe delivery of infusion therapy...Specific flush orders must be documented...Flushing is performed to ensure and maintain catheter patency...Documentaiton in the medical record includes, but is not limited to: Date and time, Prescibed flushing agent, Site assessment...." At that time, the Administrator also provided the current facility policy "Peripheral Catheter Dressing Change," revised July 1, 2012. The policy included: "...The peripheral catheter insertion site is a potential entry site for bacteria that could produce a			

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	catheter-related infection...Licensed nurses caring for residents receiving infusion therapies are expected to follow infection control and safety compliance procedures...Transparent dressings are changed with each site rotation, or sooner if the integrity of the dressing is compromised (wet, loose, soiled)...Assessment of the peripheral catheter site is performed: During dressing changes, Every 2 hours during continuous therapy...At least once a shift when not in use...." This Federal tag relates to Complaint IN00173064. 3.1-47(a)(2)			
F 469 SS=D Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on interview and record review, the facility failed to ensure a resident's room was kept free of insects, for 1 of 3 resident rooms observed, in a sample of	F 469	F 469 1. Room 139 has been deep cleaned. New receptacles for infectious waste have been placed in the room and the old receptacles were disposed of properly. The	06/10/2015

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	3. Resident A Findings include: On 5/12/15 at 9:45 A.M., during an interview with EMS Staff # 1, he indicated when he was called to the facility on 5/5/15 to transport Resident A to the hospital, he observed "the floor was extremely dirty, like it had not been swept or mopped. There were multiple boxes overflowing with old dirty linens, which looked to have fecal matter in them. There were old pop cans all over. There were bugs on the floor." On 5/13/15, the Administrator provided pest management documents. The Administrator indicated the pest management company usually came every month, but had come 2 days the previous week, and 2 days that week. A pest management report, dated 5/6/15, included, "Inspection of room [number in which Resident A resided] showed no current signs of ants. Deep cleaning had been done prior to arrival and crumbs and debris were already present in room. Exterior wall was inspected with ant activity observed in very thick and rotting mulch. Area was treated...to control future ant issues in this area."		center's Pest Control agency was notified and visited on 5/6/15 to address ants in room. 2. Center rounds were made on 5/7/15 to ensure other areas with ants present were identified and treated. Center rounds were made on 5/7/15 to ensure the room of other residents in contact isolation was clean and new receptacles were placed in their rooms. 3. Nursing staff have been retrained on notification of maintenance and administration if they find any pest present in the center. Nursing staff have been retrained on the proper handling of trash and linen for residents with infectious waste. Employees with repeated errors will be subject to disciplinary action up to and including discharge. 4. Resident room rounds will be made daily by Caring Partners (department leaders) 5 times per week. Results will be reviewed daily by the center Administrator and DON with observed issues being directed to the appropriate department leader for follow up and correction. Nursing management will make center rounds daily 5 times per week to observe resident rooms and common areas and corrections will be made as needed. Trends identified in the Caring Partner Rounds and the daily nursing rounds will be reported monthly in the center QAPI meeting monthly times 6 months and	

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	On 5/13/15 at 2:15 P.M., during an interview with the Administrator, she indicated she had become aware of a concern with Resident A's room the previous week, and had already implemented a plan of action. She indicated staff had deep cleaned Resident A's room, and she had also retrained nursing staff on the proper handling of trash and linen for residents with infectious waste. This Federal tag relates to Complaint IN00173064. 3.1-19(f)(4)		quarterly times 2 quarters to determine further recommendations.	

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