STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT ST PAULS	3602 S IRONWOOD DR SOUTH BEND, IN 46614

(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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/08/16 Facility Number: 000104 Provider Number: 155197 AIM Number: 100266590 At this Life Safety Code survey, Sanctuary at St. Paul's was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story building with a partial basement was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 78 and had a census of 74 at the time of this	K 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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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	survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/10/16 - DA			
K 0018 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Based on observation and interview, the facility failed to ensure 2 of 2 Lift storage rooms and 1 of 1 Housekeeping office contained two separate corridor doors	K 0018	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected.	06/04/2016

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	closed and positively latched into the door frame. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 between 10:59 a.m. and 1:29 p.m., the Housekeeping office, 2nd floor and 3rd floor Lift storage rooms contained two corridor doors. One of the doors had a manual slide bolt latch that was latched into the frame. The other door positively latched into the slide bolt door. 3.1-19(b)		Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Administrator is requesting an extension for noncompliance due to time frame required to complete installation of door frames to meet safety regulations. Contractor consultation obtained with quotes in progress and work to be completed by June 4, 2016. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Routine preventative maintenance to be performed per manufacturer's recommendations. Q5. By what date the systemic changes will be completed; A5. June 4, 2016	
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation, the facility failed to ensure the passage of pipe through 1 of 3 vertical openings was protected as	K 0020	Q1. What corrective action(s) will be accomplished for those residents found to have been	04/07/2016

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NAME OF PROVIDER OR SUPPLIER SANCTUARY AT ST PAULS		STREET ADDRESS, CITY, STATE, ZIP CODE 3602 S IRONWOOD DR SOUTH BEND, IN 46614	

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	appropriate for the fire resistance rating of the barrier. LSC Section 8.2.5.2 requires openings through floors, such as stairways, to be enclosed with fire barrier walls. The passage of building service materials such as pipe shall be protected so that the space between the penetrating item and the fire barrier shall be filled with a material capable of maintaining the fire resistance of the fire barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at 11:16 a.m., there were three separate unsealed penetrations in the South Stairwell wall. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)		affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager will require all Contractors providing building upgrades or repairs to check in and check out on a log. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manger will educate all maintenance associates on the Contractor policy and procedures. Maintenance associate will be required to inspect the work completed by the Contractor to ensure it meets required safety regulations. Maintenance associate to sign off on the log after the inspection has been completed validating safety compliance. Maintenance Manager to report monthly findings to MDQI/QAPI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	

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K 0021 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 2 Kitchen doors serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect staff only. Findings include: Based on observations with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at	K 0021	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager contacted	04/07/2016

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	1:17 p.m., two separate kitchen doors was held open by a device attached to the wall. Once the fire alarm was activated, only one of the two doors released with the fire alarm. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)		Contractor Kingdom Fire to repair the magnetic hold open door device to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manager to educate maintenance associates on the procedure to manually check the doors magnetic hold open device released properly during fire alarm. The facility had developed an auditing tool to implement an inspection during monthly fire drills to ensure the doors with magnetic hold open devices properly release. Maintenance Manager to report monthly findings to MDQI/QAPI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide	K 0025	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	04/07/2016

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	a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only. Findings include: Based on observations with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at 11:38 a.m., there was an unsealed three quarter inch penetration in the ceiling in the Maintenance office. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged and provided the measurement for the unsealed penetration. 3.1-19(b)		A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager will require all Contractors providing building upgrades or repairs to check in and check out on a log. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manger will educate all maintenance associates on the Contractor policy and procedures. Maintenance associate will be required to inspect the work completed by the Contractor to ensure it meets required safety regulations. Maintenance associate to sign off on the log after the inspection has been completed validating safety compliance. Maintenance Manager to report monthly findings to MDQI/QAPI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	
K 0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 1 of 2 C Stairwell exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affect staff and at least 18 residents. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at 12:32 p.m., the exit door in the path of	K 0038	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager repaired door to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manager to educate maintenance associates on the procedure to manually check the exit door of egress to ensure it properly opens. The facility auditing tool for environmental rounds has been modified to include monitoring the exit to egress door monthly by maintenance associate. Maintenance Manager to report monthly findings to MDQI/QAPI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	04/07/2016

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	egress on the 3rd floor of the C Stairwell failed to open when tested. Based on interview and the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged the aforementioned condition and couldn't explain why the door would not open. 3.1-19(b)			
K 0045 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 1 South Stairwell exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect staff and up to 36 residents. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at	K 0045	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager contacted Contractor H&G Electrical to install a light	04/07/2016

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	11:11 a.m., the South Stairwell exit discharge had only one bulb outside. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged the aforementioned condition. 3.1-19(b)		fixture to means of egress to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Routine preventative maintenance to be performed per manufacturer's recommendations. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	
K 0051 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	K 0051	Q1. What corrective action(s) will	06/04/2016

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	Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the 3rd floor Clean Utility room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at 12:48 p.m., the 3rd floor Clean Utility room had a smoke detector located thirty inches away from an HVAC vent. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)		be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Administrator is requesting an extension for noncompliance due to time frame required to complete movement of nine mounted manual fire alarm boxes to meet safety regulations. Contractor consultation obtained with quotes in progress to release funding and work to be completed by June 4, 2016 Maintenance Manager contacted Contractor Kingdom Fire to move smoke detector to meet safety regulations by April 7, 2016. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Routine preventative maintenance to be performed per manufacturer's recommendations. Q5. By what date the systemic changes will be completed; A5. June 4, 2016 IDR Reason: The Nursing Facility was built in 1980 with	

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			no significant renovations to require movement of originally installed mounted manual fire alarm boxes	
K 0064 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to ensure 11 of 12 facility's fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all staff, visitors, and residents. Findings include: Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 between 11:18 a.m. and 12:58 p.m., the following fire extinguisher maintenance tags were over six years: a) South Stairwell 01/2010 b) Maintenance office 12/2009. Additionally, no holes were punched out on the annual inspection tag. c) Laundry 12/2009	K 0064	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager contacted Contractor Kingdom Fire to change out all outdated portable fire extinguishers to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manager to complete a work order in our preventative maintenance tracking system to generate a	04/07/2016

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SANCTUARY AT ST PAULS	3602 S IRONWOOD DR SOUTH BEND, IN 46614

(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
	d) Elevator equipment room 01/2010 e) Inn drinking fountain 01/2010 f) By resident room 219 01/2010 g) 2nd floor Nurse's station 01/2010 h) By resident room 209 01/2010 i) By resident room 319 01/2010 j) By resident room 309 01/2010 k) 3rd floor Nurse's station 12/2009 Based on interview at the time of each observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged each aforementioned condition. 3.1-19(b)		reminder of the 6 year portable fire extinguisher change out requirement. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include:	K 0147	Q1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1. No resident was affected. Q2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Maintenance Manager has checked the facility for use of power strips and	04/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 03/08/2016

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	Based on observation with the Executive Director, the Administrator, and the Maintenance Manager on 03/08/16 at 11:19 a.m., a surge protector was powering a coffee pot in the Dietary office. Additionally, a different surge protector was powering a refrigerator. Based on interview at the time of observation, the Executive Director, the Administrator, and the Maintenance Manager acknowledged both aforementioned conditions. 3.1-19(b)		removed if using improperly to meet safety regulations. Q4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4. Maintenance Manager to educate maintenance associates of power strip safety regulation and restrictions. The facility auditing tool for environmental rounds has been modified to include monitoring for power strip usage weekly by maintenance associate. Maintenance Manager to report monthly findings to MDQI/QAPI Committee for 6 months. Q5. By what date the systemic changes will be completed; A5. April 7, 2016	