STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00296511. Complaint #IN0000296511: Substantiated. No deficiencies related to the allegations were cited. Unrelated deficiencies cited. Survey Dates: October 10 and 11, 2019 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed October 16, 2019 by #09182.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), and 1 discharged client (H), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) the group home remained in good repair and 2) assessments and interdisciplinary team meetings were held to discuss the staffing levels at the group home prior to reducing the amount of staffing during the overnight shift (12:00 AM to 6:00 AM).	W 0104	Maintenance requests have been submitted to Maintenance provider(attached in supporting documentation) Training with staff will be conducted on 10/30/2019 to review maintenance orders and how to document. Area Supervisor will be trained on reviewing work orders and reporting non-completed work order requests weekly to Associate Executive Director to	11/10/2019

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

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	Findings include: 1) On 10/10/19 from 12:36 PM to 5:32 PM, an observation was conducted at the group home. During the observation, the following environmental issues were noted affecting clients A, B, C, D, E, F and G. A) The front sidewalk had missing dirt on both sides of the sidewalk. There were several feet of sidewalk where the drop offs (the sidewalk's adjacent ground) were 4 inches deep. B) The front porch of the group home had weeds 5 feet tall. The weeds hung over parts of the sidewalk. The weeds covered a bench in the front of the house. C) The left side of the garage door had weeds growing from the ground to the roof. The left side of the front of the house had weeds growing from the ground to the roof. D) The vinyl siding on the north side of the group home was covered in green, tan and brown colored substances. E) The vinyl siding on the back porch of the group home was covered in a black and charcoal colored substance. F) The downspout drainage area adjacent to the back porch was sunk down into the ground several inches causing an uneven surface. G) The bushes in the front yard of the group home were long and partially covered the front windows of the group home.		ensure completion of requests. Persons responsible: Residential Manager, Area Supervisor, Associate Executive Director	

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	H) The dishwasher's soap dispenser was not opening during wash cycles. I) Client D's emergency alert strobe light, required due to his deafness, needed to be moved to his current bedroom. On 10/11/19 at 10:17 AM, a review of the facility's Service Orders was conducted and indicated the following: -On 7/4/19, an order was submitted to cut a bush in the front of the group home. -On 7/29/19, an order was submitted to cut a bush in the front of the group home. -On 7/29/19, an order was submitted to power wash the group home. -On 9/19/19, an order was submitted to maintain the landscaping. -On 8/23/19, an order was submitted to move a strobe light from one bedroom to another bedroom for fire safety. -On 8/23/19, an order was submitted indicating the dishwasher was not washing the dishes and the soap dispenser did not dispense the soap during the wash cycle. On 10/10/19 at 1:43 PM, staff #2 indicated the weeds needed to be removed from the front of the group home. Staff #2 stated the "algae" on the north side of the group home needed to be powerwashed off the home. Staff #2 stated the Home Manager was sending in work orders however "things not getting repaired timely." Staff #2 indicated dirt needed to be added to the sides of the front sidewalk due to the drop offs on each side. Staff #2 stated the dirt and the sidewalk needed to be "flat." On 10/10/19 at 12:51 PM, the Home Manager (HM) indicated the landscaping around the home			

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	needed to be completed. The HM stated the weeds were "out of control." The HM indicated the last time she called maintenance she was told the landscaping had been completed. The HM indicated it was not completed. The HM indicated the dishwasher was not working correctly. The HM indicated the soap dispenser was not opening up during the cycle therefore when the cycle was completed there was still soap in the dispenser. The HM indicated the drop offs on the sides of the front sidewalk needed to be filled in. The HM indicated client D's emergency alert strobe light needed to be moved to another bedroom due to client D changing bedrooms in August 2019. On 10/10/19 at 1:14 PM, the Qualified Intellectual Disabilities Professional assistant indicated the sidewalk gaps on the sides needed to be completed. On 10/11/19 at 10:33 AM, the assistant indicated the dirt previously added next to one side of the sidewalk was not level. The assistant stated it was "still a trip hazard." She stated the weeds were "overgrown" and the outside vinyl of the group home needed to be powerwashed due to "algae." She indicated the emergency alert strobe light should have been moved from client D's old bedroom into his current one. On 10/10/19 at 1:16 PM, the Area Supervisor (AS) indicated the group home needed to have the ground level with the sidewalk (drop offs fixed). The AS indicated the landscaping including weed removal needed to be completed. The AS stated since switching how the facility did maintenance "things are not getting done." The AS indicated the facility's vinyl siding needed to be powerwashed.			

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	On 10/10/19 at 11:01 AM, the Associate Executive Director (AED) indicated client H fell off the sidewalk and fractured his arm on 6/4/19 due to the gaps/drop offs (missing earth/uneven surface) on the sides of the sidewalk. The AED indicated the drop offs were 4-5 inches deep. The AED indicated the dirt needed to be level with the sidewalk. The AED indicated the weeds in the front of the home needed to be removed and the landscaping needed to be completed. The AED indicated the vinyl siding of the group home needed to be pressure washed. The AED indicated the downspout needed to have gravel under it to level it out. The AED indicated the emergency alert strobe light needed to be moved to client D's bedroom. 2) On 10/10/19 at 2:15 PM, a review of the facility's evacuation drills was conducted and indicated the following: -On 10/11/18 at 3:50 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 6 clients participated; A, B, C, D, E and F. -On 1/7/19 at 1:45 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 6 clients participated; A, B, C, D, E and F. -On 3/1/19 at 3:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G. -On 6/2/19 at 3:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There was 1 staff present during the drill. 8 clients participated; A, B, C, D, E, F, G and discharged client H. -On 9/3/19 at 4:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete.			

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	There were 2 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G. -On 9/13/19 at 2:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There was 1 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G. For each of the 6 overnight evacuation drills, there was no documentation on the drills of each client's elapsed time to complete the drill. No level of assistance was documented for each client. On 10/10/19 at 5:29 PM, a review of the clients' Fire Assessments was conducted and indicated the following: -Client A's 2/11/19 Fire Assessment indicated he required the assistance of 1 staff and required guidance from others. -Client B's 4/8/19 Fire Assessment indicated he required the guidance of others. -Client C's 2/11/19 Fire Assessment indicated he did not respond to the alarm, required the guidance from others and did not evacuate without assistance. -Client D's 10/16/18 Fire Assessment indicated he required total assistance to follow instructions, did not respond to alarms, required guidance from others, and did not evacuate without assistance. The Recommendations section indicated, "[Client D] is hearing impaired & (and) requires gestural prompts & strobe lights to respond to fire drills." -Client E's 12/12/18 Fire Assessment indicated he was independent with evacuating. -Client F's 4/8/19 Fire Assessment indicated he was independent with evacuating. -Client G's 3/25/19 Fire Assessment indicated he ambulated with 1 staff's assistance, required total assistance to follow instructions, did not respond to alarm, did not evacuate without assistance, was unable to find the designated area (blind) and			

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	required guidance from others to respond to evacuation drills. Confidential interview (CI) #1 indicated the administration at the group home cut the overnight staffing from 2 staff to 1 staff. CI #1 indicated there were two staff for years on the overnight shift prior to the staffing change. CI #1 stated it was "Not a safe situation with one person." CI #1 stated, "Clients are not going to get out of here (during a fire), they're just not." CI #1 indicated client A was slow to respond, client C had sensory issues with the fire alarm due to Autism, client D was deaf and had dementia and client G was blind and had ambulation issues requiring, at times, the use of a wheelchair. CI #1 indicated the staff was directed to write the drills took 3 minutes or less regardless of the amount of time it actually took. CI #1 stated were "told to falsify the documentation." CI #1 indicated if the staff documented an evacuation drill over 3 minutes, the staff had to continue, night after night, implementing evacuation drills until the drill took 3 minutes or less. CI #2 indicated 1 staff during the overnight shift was not sufficient to evacuate the clients. CI #2 stated "we were told to write drills took 3 minutes. It was actually double the amount of time." CI #2 stated "one staff was not sufficient during the overnight." CI #3 indicated a former overnight staff left working at the group home due to not wanting to work alone during the overnight shift. CI #4 indicated evacuation drills took 6-7 minutes to conduct however staff was instructed to write it took 3 minutes. CI #4 indicated he was told by administrative staff to write 3 minutes regardless			

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	of the actual time it took. CI #4 indicated 1 staff during the overnight shift was not sufficient. On 10/10/19 at 5:00 PM, the Home Manager (HM) indicated staffing changed in April 2019 after a former overnight staff quit. The HM indicated the staffing level was changed without an interdisciplinary team meeting or new assessments being conducted. The HM indicated one staff was not sufficient due to the needs of the clients. The HM indicated clients C, D and G did not respond to the fire alarm. The HM stated, "How's one person going to get 3 people out?" The HM indicated if the evacuation drills were not completed in less than 3 minutes, the staff had to continue repeating the drills until the drill was less than 3 minutes. The HM indicated she did not believe the times on the overnight drills were accurate. The HM stated, "Can't do it (in less than 3 minutes)." The HM indicated the times on the drills needed to be accurate. On 10/11/19 at 10:33 AM, the Qualified Intellectual Disabilities Professional assistant stated "I don't see how they can get 8 (clients) out in 3 minutes." She indicated client G did not respond to prompts, client D was deaf and client A needed prompting. She indicated the evacuation drills needed to be timed for each client. She stated, "I don't know who would tell them to write 3 minutes. Never told them to falsify documentation." She indicated the policy requires the repeating of the evacuation drills until the drills were conducted under 3 minutes. She indicated she was not involved in the decision to change the staffing at the group home. She stated, "I don't know why" the staffing level was changed from 2 staff to 1 staff. She stated "It requires 2 staff for the overnight due to the amount of assistance needed (by the clients)." She indicated there were no			

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	interdisciplinary team meetings and no client assessments prior to decreasing the staffing level at the group home. She stated, "I was not involved." She stated, "I learned about it after it took effect." On 10/11/19 at 11:01 AM, the Associate Executive Director (AED) indicated the evacuation drills needed to have the exact times documented for each client. The AED stated, "Staff (were) never told to write 3 minutes... I've not directed them to write 3 minutes." The AED indicated the evacuation drills should have a time for each client. The AED indicated his understanding of the overnight shift was 2 staff were not needed. The AED indicated he changed the staffing during the overnight shift to use the hours during awake times. The AED indicated there were no meetings and no assessments conducted prior to him making the change. The AED indicated he reviewed the evacuation drills and there were no issues noted. The AED stated, "I never saw a reason to have 2 staff." 9-3-1(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 20 incident reports reviewed affecting former client H, the facility failed to ensure appropriate corrective action was implemented following an incident of client H falling resulting in a fracture. Findings include: 1) On 10/10/19 from 12:36 PM to 5:32 PM, an	W 0157	Qualified Intellectual Disability Professional(QIDP) and Area Supervisor will be trained on conducting follow up to recommendations from IDT and Investigations on 10/30/2019 All investigations will be review by Associate Executive Director to ensure that corrective action to be taken is completed in a timely	11/10/2019

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	observation was conducted at the group home. The front sidewalk had missing dirt on both sides of the sidewalk. There were several feet of sidewalk where the drop offs (the sidewalk's adjacent ground) were 4 inches deep. On 10/10/19 at 4:45 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/4/19 at 11:56 AM, client H had fallen resulting in a fracture to his left humerus (upper arm bone) with a three and one half inch bruise. The 6/5/19 Incident Report indicated, in part, "It was reported that [client H] was sitting on the porch while staff was in the house. Staff heard [client H] yell and went outside. [Client H] had fallen and said he could not move his arm. Staff called sheriff department requesting ambulance. [Client H] was transported to IU (Indiana University) Health. X rays were taken, and it was determined that [client H] has a fracture to his left humerus with a three and one half inch bruise." The 6/4/19 - 6/11/19 Investigation Summary indicated in the Summary of Interview with client H on 6/6/19 "He and [sic] were the only ones at the home when he fell. He told [sic] he was going to go sit on the porch and wait for her because they were getting ready to go somewhere. He lost his balance and fell in the landscaping, mulch. He never made it to the chair because he fell as soon as he went outside. He was not wearing his knee brace because he had shorts on and he doesn't like to wear the brace with shorts. Staff told him to put his brace on that morning, but he didn't want to. His walker should have been right there where he fell. He thinks the fire fighter moved the walker onto the porch. The fire fighter got him up and sat him in a chair then the ambulance took him to the hospital and they told him he broke his		manner Persons responsible: QIDP, Area Supervisor, Associate Executive Director	

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	arm." The Factual Findings section indicated, "Witness statements, photographs and physical inspection of the area confirm the fall occurred at the front of the house at the step off on the front porch and that [client H] fell into the mulch to the left of the front sidewalk." The 6/19/19 Investigation's Peer Review Recommendations indicated "Revises fall high risk plan (HRP) to include use of walker/cane knee brace and bed rails during sleep hours. Retrain all staff on fall HRP." There was no documentation of corrective action to the area (sidewalk with missing earth/uneven surface) where the fall occurred to prevent future issues. On 10/10/19 at 1:43 PM, the staff #2 indicated fill dirt had been put in the area of the fall, "but it had not packed down." On 10/11/19 at 10:33 AM, the Qualified Intellectual Disabilities Professional Assistant indicated the dirt used had lowered again, maybe two inches, "no grass or straw was put over it." The assistant indicated there was a drop off (area of missing earth 4-5 inches deep) from the sidewalk to the landscaped area On 10/11/19 at 11:01 AM, the Associate Executive Director (AED) indicated the sidewalk coming around the curve was too high and dirt had been added with seeding. The AED indicated dirt needed to be added and made level to the sidewalk. On 10/10/19 at 1:43 PM, staff #2 indicated dirt needed to added to the sides of the front sidewalk due to the drop offs (area of missing earth 4-5 inches deep) on each side. Staff #2 stated the dirt and the sidewalk needed to be "flat."			

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	On 10/10/19 at 12:51 PM, the Home Manager (HM) indicated the drop offs (missing earth 4-5 inches deep) on the sides of the front sidewalk needed to be filled in On 10/10/19 at 1:14 PM, the Qualified Intellectual Disabilities Professional assistant indicated the sidewalk gaps on the sides needed to be completed. On 10/11/19 at 10:33 AM, the assistant indicated the dirt previously added next to one side of the sidewalk was not level. The assistant stated it was "still a trip hazard." On 10/10/19 at 1:16 PM, the Area Supervisor (AS) indicated the group home needed to get the drop offs on the sidewalk fixed. On 10/10/19 at 11:01 AM, the Associate Executive Director (AED) indicated client H fell off the sidewalk and fractured his arm on 6/4/19 due to the gaps/drop offs (missing earth/uneven surface) on the sides of the sidewalk. The AED indicated the drop offs were 4-5 inches deep. The AED indicated the dirt needed to be level with the sidewalk. 9-3-2(a)			
W 0446 Bldg. 00	483.470(i)(2)(ii) EVACUATION DRILLS The facility must make special provisions for the evacuation of clients with physical disabilities. Based on interview and record review for 7 of 7 clients living in the group home (A, B, C, D, E, F and G), the facility failed to ensure there were assessments completed of the clients' abilities to evacuate the group home prior to decreasing the amount of staff during the overnight shift (12:00	W 0446	Staff will be trained on 10/30/2019 in regards to drill completion and accurate documentation of drills Drill schedule included in supporting documentation	11/10/2019

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	AM to 6:00 AM). Findings include: 1) On 10/10/19 from 12:36 PM to 5:32 PM, an observation was conducted at the group home. During the observation, the following environmental issues were noted affecting clients A, B, C, D, E, F and G. A) The front sidewalk had missing dirt on both sides of the sidewalk. There were several feet of sidewalk where the drop offs (the sidewalk's adjacent ground) were 4 inches deep. On 10/10/19 at 2:15 PM, a review of the facility's evacuation drills was conducted and indicated the following: -On 10/11/18 at 3:50 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 6 clients participated; A, B, C, D, E and F. -On 1/7/19 at 1:45 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 6 clients participated; A, B, C, D, E and F. -On 3/1/19 at 3:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G. -On 6/2/19 at 3:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There was 1 staff present during the drill. 8 clients participated; A, B, C, D, E, F, G and discharged client H. -On 9/3/19 at 4:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There were 2 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G.		After assessment schedule is complete one drill per month for 3 months will be observed by supervisors to ensure that drill and documentation are completed accurately. Persons responsible: Residential Manager, QIDP, Area Supervisor, Associate Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	10/11/2019

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	-On 9/13/19 at 2:00 AM, an evacuation drill was conducted. The drill took 3 minutes to complete. There was 1 staff present during the drill. 7 clients participated; A, B, C, D, E, F and G. .For each of the 6 overnight evacuation drills, there was no documentation on the drills of each client's elapsed time to complete the drill. There was no documentation of each client's level of assistance required to complete the drills. On 10/10/19 at 5:29 PM, a review of the clients' Fire Assessments was conducted and indicated the following: -Client A's 2/11/19 Fire Assessment indicated he required the assistance of 1 staff and required guidance from others. -Client B's 4/8/19 Fire Assessment indicated he required the guidance of others. -Client C's 2/11/19 Fire Assessment indicated he did not respond to the alarm, required the guidance from others and did not evacuate without assistance. -Client D's 10/16/18 Fire Assessment indicated he required total assistance to follow instructions, did not respond to alarms, required guidance from others, and did not evacuate without assistance. The Recommendations section indicated, "[Client D] is hearing impaired & (and) requires gestural prompts & strobe lights to respond to fire drills." -Client E's 12/12/18 Fire Assessment indicated he was independent with evacuating. -Client F's 4/8/19 Fire Assessment indicated he was independent with evacuating. -Client G's 3/25/19 Fire Assessment indicated he ambulated with 1 staff's assistance, required total assistance to follow instructions, did not respond to alarm, did not evacuate without assistance, and was unable to find the designated area (blind) without help.			

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	Confidential interview (CI) #1 indicated the administration at the group home cut the overnight staffing from 2 staff to 1 staff. CI #1 indicated there were two staff for years on the overnight shift prior to the staffing change. CI #1 stated it was "Not a safe situation with one person." CI #1 stated, "Clients are not going to get out of here (during a fire), they're just not." CI #1 indicated client A was slow to respond, client C had sensory issues with the fire alarm due to Autism, client D was deaf and had dementia and client G was blind and had ambulation issues requiring, at times, the use of a wheelchair. CI #1 indicated the staff were directed to write the drills took 3 minutes or less regardless of the amount of time it actually took. CI #1 stated were "told to falsify the documentation." CI #1 indicated if the staff documented an evacuation drill over 3 minutes, the staff had to continue, night after night, implementing evacuation drills until the drill took 3 minutes or less. CI #2 indicated 1 staff during the overnight shift was not sufficient to evacuate the clients. CI #2 stated "we were told to write drills took 3 minutes. It was actually double the amount of time." CI #2 stated "one staff was not sufficient during the overnight." CI #3 indicated a former overnight staff left working at the group home due to not wanting to work alone during the overnight shift. CI #4 indicated evacuation drills took 6-7 minutes to conduct however staff was instructed to write it took 3 minutes. CI #4 indicated he was told by administrative staff to write 3 minutes regardless of the actual time it took. CI #4 indicated 1 staff during the overnight shift was not sufficient.			

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	On 10/10/19 at 5:00 PM, the Home Manager (HM) indicated staffing changed in April 2019 after a former overnight staff quit. The HM indicated the staffing level was changed without an interdisciplinary team meeting or new assessments being conducted. The HM indicated one staff was not sufficient due to the needs of the clients. The HM indicated clients C, D and G did not respond to the fire alarm. The HM stated, "How's one person going to get 3 people out?" The HM indicated if the evacuation drills were not completed in less than 3 minutes, the staff had to continue repeating the drills until the drill was less than 3 minutes. The HM indicated she did not believe the times on the overnight drills were accurate. The HM stated, "Can't do it (in less than 3 minutes)." The HM indicated the times on the drills needed to be accurate. On 10/11/19 at 10:33 AM, the Qualified Intellectual Disabilities Professional assistant stated "I don't see how they can get 8 (clients) out in 3 minutes." She indicated client G did not respond to prompts, client D was deaf and client A needed prompting. She indicated the evacuation drills needed to be timed for each client. She stated, "I don't know who would tell them to write 3 minutes. Never told them to falsify documentation." She indicated the policy requires the repeating of the evacuation drills until the drills were conducted under 3 minutes. She indicated she was not involved in the decision to change the staffing at the group home. She stated, "I don't know why" the staffing level was changed from 2 staff to 1 staff. She stated "It requires 2 staff for the overnight due to the amount of assistance needed (by the clients)." She indicated there were no interdisciplinary team meetings and no client assessments prior to decreasing the staffing level			

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	at the group home. She stated, "I was not involved." She stated, "I learned about it after it took effect." On 10/11/19 at 11:01 AM, the Associate Executive Director (AED) indicated the evacuation drills needed to have the exact times documented for each client. The AED stated, "Staff (were) never told to write 3 minutes... I've not directed them to write 3 minutes." The AED indicated the evacuation drills should have a time for each client. The AED indicated his understanding of the overnight shift was 2 staff were not needed. The AED indicated he changed the staffing during the overnight shift to use the hours during awake times. The AED indicated there were no meetings and no assessments conducted prior to him making the change. The AED indicated he reviewed the evacuation drills and there were no issues noted. The AED stated, "I never saw a reason to have 2 staff." 9-3-7(a)			