

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/11/2012
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005036</p> <p>Survey Date: 4-9/11-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Cleone Peterson Medical Surveyor</p> <p>QA: claughlin 04/20/12</p>	S0000		

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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S0270	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6)</p> <p>(a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following:</p> <p>(6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up.</p> <p>Based on document review and interview, the governing board failed to review reports of quality monitoring activities for 1 contracted service.</p> <p>Findings:</p> <p>1. Review of the governing board minutes for calendar year indicated they lacked review of reports for the contracted tissue transplant service.</p> <p>2. In interview, on 4-11-12 at 4:30 pm, employee #A2 indicated no report for the above service was reviewed by the governing board in calendar year 2011 and no further documentation was provided prior to exit.</p>	S0270	<p>Corrective Action: Quality indicators were being collected by the Surgicial Services Department at the time of the survey however they were not being reported to the Board of Trustees. The collection tool was revised on April 10, 2012 to include time ordered, time delivered, and vendor name. The tool was implemented on April 12, 2012. The Operating Supervisor was made aware on May 3, 2012 that she will need to provide a summary to the Team Leader of Surgical Services for report to the Board of Trustees on a quarterly basis. The implantable tissue summary of findings/results was placed on the Board of Trustees agenda (May 3, 2012) for the next Board of Trustees meeting on May 30, 2012. Responsible Person: Team Leader, Surgical Services Preventative</p>	05/03/2012			

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			Action:Quality indicators will be tracked and trended and a quarterly summary of results will be provided to the Board of Trustees, with the first report to be given at the next Board of Trustees meeting on May 30, 2012.Responsible Person: Team Leader, Surgical Services	

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S0332	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(L)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(L) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying inservicing in special procedures.</p> <p>Based on interview and document review, the facility failed to ensure that personnel administering medications had demonstrated and documented the competency in administering medications for 1 offsite.</p> <p>Findings include:</p> <p>1. On 04-10-12 at 1300 hours, staff #49 confirmed that radiology technicians administer medication nebulizer treatments to patients at the Urgent Care offsite.</p> <p>2. Review of staff #11's personnel file indicated that staff #11 was a radiology technician who worked at the Urgent Care offsite and lacked documentation of training and competency in administering</p>	S0332	<p>Corrective Action: The Clinical Manager instructed the Radiology Technicians that they are not to administer any type of medication (April 10, 2012). The Team Leader counseled the Clinical Manager on leadership responsibilities of verifying staff's job responsibilities according to their job description and required competencies (April 13, 2012). Job description was posted for Radiology Technicians to review (April 10, 2012). The Clinical Manager will review the job description with individual staff members during annual evaluations which will be completed by May 21, 2012 (May 21, 2012). Computer access to the Medication Administration Record was removed (April 10, 2012). Preventative Action: Radiology Technicians' practice will be monitored on an</p>	05/21/2012			

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	<p>medication nebulizer treatments.</p> <p>3. Review of staff #11's job description, Radiology Tech - General, indicated the following:</p> <p>1. Ability to administer IV contrast as directed by Radiologist. The job description lacked documentation of administering medication nebulizer treatments.</p>		<p>ongoing basis and any deviation from the scope of practice will be addressed by the Clinical Manager and reported to the Team Leader and Chief Nursing Officer. Responsible Person: Clinical Manager Date: Ongoing beginning April 10, 2012 Medication Administration Records will be reviewed on no less than a quarterly basis to ensure Radiology Technicians are not practicing outside their scope. Findings will be reported to the Hospital Quality Council the month following the end of a quarter. Responsible Person: Team Leader, Prime Time Urgent Care Date: First Report to Hospital Quality Council - July 2012</p>		

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S0362	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D) (E)(F)</p> <p>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</p> <p>6) Ensure that the hospital does the following:</p> <p>(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants.</p> <p>Based on document review, the hospital failed to comply with their contract by not notifying their organ procurement organization of 6 of 154 deaths for the year 2011.</p>	S0362	The Indiana Organ Procurement Organization (IOPO) report is reviewed each time it is received with attention paid to any missed organ referrals. During the year, Tim Geyer was notified of	04/25/2012			

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	<p>Findings:</p> <p>1. Review of the contract between the hospital and the Indiana Organ Procurement Organization (IOPO), dated February 15, 2007, indicated [the] hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), in the Hospital.</p> <p>2. Review of a report entitled Hancock Regional Hospital Donation 2011 Statistics and Benchmarks, indicated that for the period January 1, 2011 through December 31, 2011, there were 160 hospital deaths and 154 were reported to IOPO.</p>		<p>inconsistencies between hospital discharges and IOPO reporting of missed notification. IOPO reported six deaths as not reported. Of those six deaths, only one was not called. The nurse that missed the notification was a new nurse and she received re-education on the process and has not failed to notify since the incident. The five patients that reported as non-notification were reconciled with IOPO and included: 1. Patient L.A. - Hospice patient died at home. 2. Patient D.A. - Hospice patient died at home. 3. Patient R.B. - Home care patient died at home. 4. Patient M.S. - Did not die at Hancock Regional Hospital. Discharged in the computer from the labe due to standing order for blood draw. 5. Patient M.B. - Hospice patient died at home. During the year Mr. Geyer received a promotion and Mr. Chris Dennis became the new Professional Services Coordinator. Mr. Geyer always upated the IOPO report with revised information. During the transition period the reports were not updated. Mr. Dennis has been notified and he states he will update the information. Corrective Action: Non-notification of IOPO deaths was reviewed and reconciliation notification again sent to IOPO for updating of records (April 24, 2012). Evaluation of notification system found a computer system</p>				

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			reporting issue. Prior to the computer system upgrade, deaths sent to IOPO were electronically pulled from one source. With the upgrade, the system started pulling any disposition listed as expired so included order discharges from lab, home care and hospice, etc. This issue has been resolved and IOPO should now only receive notification of appropriate deaths (April 25, 2012). Preventative Action: Reports will continue to be reviewed as received and any non-notification will be evaluated. If the IOPO should have been notified, corrective action will be taken with staff involved and IOPO will be notified of action taken. If the death should not have been reported, IOPO will be notified and a request made to revise their report (Ongoing Process).		

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S0732	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) contained sufficient information to document accurately the course of treatment and justify the treatment for 1 of 20 MRs reviewed (Patient #1).</p> <p>Findings include:</p> <p>1. On 04-10-12 at 1000 hours during the facility tour of the Post Anesthesia Care Unit (PACU), patient #1's MR was reviewed. The Post Anesthesia Evaluation was documented as being completed on 04-10-12 at 1030 hours.</p> <p>2. On 04-10-12 at 1000 hours, staff #44 confirmed that the Post Anesthesia Evaluation was documented as being completed on 04-10-12 at 1030 hours.</p>	S0732	<p>Corrective Action: The Team Leader of Health Information Services met with the physician to discuss the inaccurate timing of the medical record and discussed the importance of attention to detail when documenting in the medical record (April 27, 2012). This physician verbalized understanding of the expectation that all patient documentation be accurately documented. The Vice President of Medical Staff Services and the Medical Staff President were also notified by the Team Leader of Health Information Services of the occurrence (April 25, 2012). Responsible Person: Team Leader, Health Information Services Preventative Action: Documentation review process implemented on May 3, 2012. The review will be performed by the PACU staff on a daily basis of each Post Anesthesia Evaluation completed by the Anesthesiologists to ensure compliance with the standard and documented on a log</p>	05/03/2012			

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			(Attachment 1). The Team Leader of Surgical Services will be immediately notified of any discrepancy between assessment and documentation time. The Team Leader of Surgical Services will then notify the Team Leader of Health Information Services, Vice President of Medical Staff Services, Anesthesia Director, and Medical Staff President. The log will be reviewed by the Medical Executive Committee on a quarterly basis with first submission in the third quarter 2012. The log will also be reviewed by the Corporate Compliance Committee twice per year in January and July, with first submission July 2012. Responsible Person: Team Leader, Surgical Services	

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S0932	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on document review, the facility failed to ensure that the nursing service follow established policy/procedure for reviewing nursing care plans for 7 of 8 nursing care plans reviewed (Patient # 2, 14, 15, 16, 17, 18 and 19).</p> <p>Findings include:</p> <p>1. Review of policy/procedure IM 320, Chart Checks and Care Plan Reviews, indicated the following: "Plan of Care Review 1. Every patient's Plan of Care needs to be reviewed by an RN a minimum of once per 8 hours. All components of the patient's care plan should be reviewed and adjustments made as necessary. 2. Document Care Plan Review appropriately. 3. The nurse completing the plan of care review will document the review in Meditech." This policy/procedure was last reviewed/revised on 07-18-11.</p>	S0932	<p>Corrective Action:Daily chart audits of all patients' care plan review were implemented on April 10, 2012. An educational email was sent to associates on April 11, 2012 regarding the policy and reinforcing the proper way to document the review electronically. Staff was given the policy to review and was required to sign that they have read the policy and process; completed May 2, 2012 except for those on leave of absence. As RNs on leave of absence return to work, they will be provided with the same education and will have the same requirement to provide a signature confirming they have read the policy and process.Responsible Person: Unit CoordinatorPreventative Action:The education/re-education process was implemented on April 25, 2012 to address non-compliance with care plan review. Staff found to be non-compliant receive education/re-education for a first offense and documentation placed in their file. Continued</p>	05/02/2012			

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	<p>2. Review of patient #2's MR indicated the patient was admitted to the facility on 04-07-12 and the patient's care plan was reviewed on 04-07-12 at 2241 hours; the next documented review was on 04-08-12 at 0738 hours; the next documented review was on 04-09-12 at 0012 hours; the next documented review was on 04-09-12 at 0735 hours; the next documented review was on 04-10-12 at 0029 hours and the next documented review was on 04-10-12 at 1233 hours.</p> <p>3. Review of patient #14's MR indicated the patient was admitted to the facility on 02-09-12 and the patient's care plan was reviewed on 02-10-12 at 0233 hours, the next documented review was on 02-10-12 at 2119 hours and the next documented review was on 02-11-12 at 1229 hours.</p> <p>4. Review of patient #15's MR indicated the patient was admitted to the facility on 02-12-12 at 2007 hours and the patient's care plan was reviewed on 02-14-12 at 0725 hours, the next documented review was on 02-14-12 at 2157 hours and the next documented review was on 02-15-12 at 1619 hours.</p> <p>5. Review of patient #16's MR indicated the patient was admitted to the facility on 02-15-12 and the patient's care plan was</p>		non-compliance results in progressive corrective action. Responsible Person: Team Leader, Acute Care Services				

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	<p>reviewed on 02-15-12 at 1951 hours; the next documented review was on 02-16-12 at 1044 hours; the next documented review was on 02-16-12 at 2213 hours; the next documented review was on 02-17-12 at 1232 hours; the next documented review was on 02-17-12 at 1935 hours and the next documented review was on 02-18-12 at 1007 hours.</p> <p>6. Review of patient #17's MR indicated the patient was admitted to the facility on 02-23-12 at 0809 hours and the patient's care plan was reviewed on 02-23-12 at 1248 hours; the next documented review was on 02-24-12 at 0106 hours; the next documented review was on 02-24-12 at 0537 hours; the next documented review was on 02-24-12 at 2018 hours and the next documented review was on 02-25-12 at 0832 hours.</p> <p>7. Review of patient #18's MR indicated the patient was admitted to the facility on 02-07-12 at 2216 hours and the patient's care plan was reviewed on 02-08-12 at 2021 hours; the next documented review was on 02-09-12 at 0906 hours; the next documented review was on 02-10-12 at 0110 hours and the next documented review was on 02-10-12 at 1311 hours.</p> <p>8. Review of patient #19's MR indicated the patient was admitted to the facility on</p>				

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	02-07-12 and the patient's care plan was reviewed on 02-08-12 at 0042 hours, the next documented review was on 02-08-12 at 1244 hours, the next documented review was on 02-09-12 at 0440 hours. The care plan was reviewed on 02-09-12 at 2035 hours, the next documented review was on 02-10-12 at 0853 hours and the next documented review was on 02-10-12 at 2306 hours.			

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S1022	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions.</p> <p>Based on observation and interview, the hospital failed to secure access to 1 drug storage area within the hospital.</p> <p>Findings:</p> <p>1. On 4-9-11 at 12:50 pm, in the presence of employee #A9, it was observed in the hospital's Pharmacy there was a Controlled II substance, morphine drip, 25mg/ml in a 250ml vial, stored in an unlocked refrigerator.</p> <p>2. In interview, on 4-9-11 at 12:50 pm, employee #A9 indicated the refrigerator was required to be locked because it contained a Controlled II substance.</p>	S1022	<p>Corrective Action: Staff available at the time of the survey were re-educated about the requirement to keep controlled substances secured in a locked area (April 10, 2012). All staff were re-educated in the April staff meeting about proper storage of controlled substances (April 25, 2012). Responsible Person: Team Leader, Pharmacy</p> <p><b>Preventative Action:</b> Proper storage of controlled substances will be monitored by random audits once per month and action taken if found to be out of compliance. The first audit will be completed by May 11, 2012. Responsible Person: Team Leader, Pharmacy</p>	05/11/2012	

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S1128	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(c)(1)</p> <p>(c) In new construction, renovations, and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following:</p> <p>(1) The 2001 edition of the national "Guideline for Construction and Equipment of Hospitals and Medical Facilities" (Guidelines).</p> <p>Based on document review, observation and interview, the facility failed to ensure renovation of the Emergency Department sterile and clean supply room met the requirements of the 2001 edition of the national "Guideline for Construction and Equipment of Hospitals and Medical Facilities" (Guidelines) and failed to have a nurse call system in 1 bathroom used by inpatients.</p> <p>Findings include:</p> <p>1. Review of the 2001 Guidelines indicated the following; "7.28.B8. Ceiling finishes in semi-restricted areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and minor surgical procedure rooms must be smooth, scrubbable,</p>	S1128	<p>Corrective Action - Ceiling in Emergency Department:Quote obtained and ceiling scheduled to be replaced with a gasket seal grid system. The ceiling work is scheduled and will be completed by May 11, 2012 (Attachment 2).Responsible Person: Team Leader, Building ServicesCorrective Action - CT Nurse Call System:Nurse call system was installed on April 10, 2012 (Attachment 3).Responsible Person: Team Leader, Building Services</p>	05/11/2012			

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	<p>non-absorptive, non-perforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacterial growth. If lay-in-ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semi-restricted environment. Perforated, tegular, serrated cut, or highly textured tiles are not acceptable."</p> <p>2. During the facility tour of the Emergency Department on 04-09-12 at 1100 hours, the following was observed in the sterile/clean supply room; sterile supplies stored on shelves and the lay in ceiling tiles were non smooth and had holes.</p> <p>3. Review of the 2001 edition of the national "Guidelines for Construction and Equipment of Hospital and Medical Facilities" , section 7.32.G2, indicates a nurses emergency call system shall be provided at each inpatient toilet. A nurses emergency call shall be accessible to a collapsed patient lying on the floor. Inclusion of a pull cord will satisfy this standard.</p> <p>4. On 4-9-12 at 12:15 pm in the presence</p>				

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	<p>of employee #A6, it was observed in a restroom adjacent to CT Scan I room, there was a restroom that did not have a nurses emergency call system.</p> <p>3. In interview, on 4-9-12 at 12:15 pm, a radiology staff employee indicated inpatients use that restroom.</p>			

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S1164	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(B)</p> <p>(d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows:</p> <p>(B) There shall be evidence of preventive maintenance on all equipment.</p> <p>Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. On 4-9-12 at 11:20 pm, employee #A6 was requested to provide documentation of PM on a stair step device and a Total Gym Exerciser, asset number 04828, both located in the Physical Therapy department. No documentation was provided prior to exit.</p>	S1164	<p>Corrective Action: The two pieces of equipment that were found not to be tagged have had preventative maintenance completed and assigned tag numbers 060133 and 060135. Maintenance will check all clinical areas to ensure equipment is tagged and preventative maintenance completed (May 2, 2012). Responsible Person: Team Leader, Building Services</p> <p>Preventative Action: The equipment has been added to the preventative maintenance rotation to ensure routine maintenance and documentation. Responsible Person: Team Leader, Building Services</p>	05/02/2012			

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S1186	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with hospital policy for 6 of 6 offsite facilities.</p> <p>Findings:</p> <p>1. Review of hospital Policy #: 5002, entitled FIRE WARNING SYSTEMS, FIRE DRILLS, LIFE SAFETY FEATURES, indicated fire drills are conducted once per shift per quarter.</p>	S1186	<p>Corrective Action:Policies revised to require any offsite facilities operating under the hospital's license to have have fire drills conducted once per shift per quarter (May 1, 2012) (Attachment 4).All offsite facilities are scheduled for and will have fire drills completed prior to May 20, 2012.Responsible Person: Team Leader, Building ServicesPreventative Action:All offsite facilities have been added to the quarterly fire drill rotation. Fire drills will be conducted and documentation</p>	05/20/2012			

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	<p>2. Review of a document entitled EVALUATION SCHEDULE, EVENT Annual Fire Drill, dated December 2011, indicated 6 of 6 hospital offsites, which are part of the hospital's license, had fire drills conducted only once in calendar year 2011: The offsites were New Palestine Family Medicine, Knightstown Health Care, McCordsville Radiology, McCordsville Physical Therapy, McCordsville Lab, Prime Time/Urgent Care.</p> <p>3. In interview, on 4-11-12 at 3:30 pm, employee #A6 indicated each offsite was operational 1 shift per day and there was only 1 fire drill conducted at each of the above offsites in calendar year 2011.</p>		maintained. Responsible Person: Team Leader, Building Services.		