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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>105734 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>10/31/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Solaris Healthcare Osceola |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4201 W New Nolte Road<br>Saint Cloud, FL 34772 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840</b></p> <p>Based on interview, and record review, the facility failed to prevent an avoidable accident with major injury for a physically impaired resident by failing to ensure the care plan was followed for transfers with mechanical lifts for 1 of 4 residents sampled for accidents, (#1). These failures contributed to a staff member disregarding a resident's prescribed transfer method and resulted in the resident sustaining a left knee fibular head fracture.</p> <p>On 10/11/24 at approximately 11:45 AM, Certified Nursing Assistant (CNA A) was in resident #1's room to get her up for a shower. Resident #1 requested to use her personal four-wheel walker for the transfer from bed to wheelchair instead of the mechanical lift. CNA A brought the walker over to the bedside and resident #1 attempted to use the walker and CNA A's assistance to stand. Shortly after standing, resident #1 complained of weakness to her legs and started to go down to the floor. CNA A was beside her and assisted her as much as she could, down to the floor. CNA A called for help and two staff members came to the room to assist. At 12:35 PM, the resident was assessed by the nurse, and she complained of leg and knee pain, and an order was obtained for the resident to be sent to the hospital. Resident #1's family was notified, and she was transported via Emergency Services (EMS) to the hospital. At 6:30 PM, the facility was notified by the hospital that resident #1 had suffered a fibular head fracture to the left knee.</p> <p>The facility's failure to provide supervision and oversight for staff members during transfers to ensure residents who were physically impaired and dependent for transfers were being transferred safely, appropriately, and per their individual care plans, placed all physically impaired residents requiring total assistance and mechanical lifts at risk for serious harm or serious injury. This failure resulted in Immediate Jeopardy starting on 10/11/24 and was removed on 10/15/24.</p> <p>Findings:</p> <p>Resident #1, a [AGE] year old female, was readmitted to the facility on [DATE] from an acute care hospital. She had diagnoses that included congestive heart failure, oxygen dependence, severe morbid obesity, difficulty walking, generalized muscle weakness, and a history of traumatic fracture. A day after her admission on 9/27/24, resident #1 weighed 353.2 pounds by mechanical lift.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of resident #1's reentry Minimum Data Set assessment with Assessment Reference Date of 10/02/24 revealed the resident's cognition was intact with a Brief Interview for Mental Status score of 15/15. The assessment indicated she was dependent, meaning she required the assistance of 2 or more staff members with mechanical lift, for bed mobility, sit to stand, transfers from bed to chair/chair to bed, and toilet transfers. The assessment further indicated that resident #1 did not attempt to walk 10 feet due to medical conditions or safety concerns.</p> <p>The medical record for resident #1 revealed she received Physical Therapy (PT) from 9/28/24 to 10/02/24. The PT discharge note dated 10/03/24 indicated the therapist documented that resident #1 would require a mechanical lift if she wanted to get out of bed due to her dependent status. The therapist documentation included that on 10/02/24 transfer out of bed to chair and ambulation were not attempted due to medical conditions or safety concerns. The therapist concluded that the resident was no longer appropriate for therapy at that time due to her medical status and resident being dependent for mobility. The note indicated the resident status and recommendations were communicated to the facility staff.</p> <p>Review of resident #1's PT progress notes dated 10/07/24 therapy performed a quarterly PT screen and found no changes in the resident status of non-ambulatory, and the screen recommended the use of a mechanical lift for transfers.</p> <p>Resident #1 had a care plan for Activities of Daily Living (ADLs) initiated on 7/02/24. The care plan interventions included a three person assist with transfers using the mechanical lift for safety initiated on 8/10/24. This intervention was a shared task for CNAs, nursing, and therapy staff. Other interventions for ADLs and mobility included a two person assist with bathing and toilet transfers using a mechanical lift.</p> <p>A change in condition progress note dated 10/11/24 revealed resident #1 had sustained a fall when she stood and lost her balance. The note detailed resident #1 slid onto the floor causing injury to her left knee and was sent to the emergency room for further evaluation. A nursing note entered later on the same day further detailed the incident reporting that CNA A was assigned to resident #1 and was assisting her to stand so that she could transfer into the wheelchair. The resident had verbalized to the CNA that she was able to stand and transfer into chair without the mechanical lift. The note indicated the resident twisted her left knee when she fell and was sent to the emergency room related to increased pain to the knee.</p> <p>The Hospital Emergency Report dated 10/11/24 at 3:00 PM, revealed Computerized Tomography (CT) scan of resident #1's left knee without contrast showed she sustained a non-displaced fracture of the fibula.</p> <p>The fibula helps stabilize and support your leg, body, ankle and leg muscles. It runs parallel to the tibia, the larger bone that forms the shin and attaches to the ankle and knee. A fibular head fracture is a break in the fibula bone near the knee, (retrieved on 11/08/24 from www.healthline.com).</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The facility provided a timeline of the incident as it was reported to the facility's Risk Manager. On 10/11/24 at 11:45 AM, CNA A was in resident #1's room to assist her in the shower area. The resident requested to use her personal four-wheel walker for the transfer from bed to wheelchair. CNA A brought the walker over to the bedside and the resident attempted to stand with CNA A's assistance and use of the walker. Her legs became weak and CNA A lowered resident to the floor. At 12:35 PM, a nurse assessed the resident and contacted the physician who gave the order for the resident to be sent to the emergency room for evaluation due to resident complaint of knee/leg pain. The family was notified and were with her at the facility after the fall. The facility contacted the hospital at 6:30 PM, and it was revealed that a CT scan confirmed the resident had suffered a fibular fracture.</p> <p>On 10/30/24 at 11:04 AM, resident #1 was lying in bed talking to a visitor. She recalled that on the day she fell CNA A came to the room to get her out of bed for a shower and asked her how she was feeling. The resident explained she told the CNA that she was feeling strong and didn't want to use the mechanical lift. Resident #1 explained staff did not always use the mechanical lift because sometimes she had felt strong enough to use her walker. She recalled that on that day, CNA A was by herself in the room and no other staff members were present to assist with her transfer. She explained the CNA unlocked the bed to push it against the wall to allow for more room, then she attempted to stand up with the help of the walker and CNA A. She recalled when she stood up, she felt her legs were like stone, so she tried to sit back down, but the bed was not locked, and it moved away from her causing her to fall. In the process of falling, she twisted her left leg and hurt her knee. She said she was sent to the hospital and told that she had a fracture. She explained she received an order for pain medication and was told she would need to follow up with the doctor in two days.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 10/30/24 at 4:33 PM, a phone interview was conducted with CNA A. She said she worked the 7:00 AM to 3:00 PM shift on 10/11/24 and was assigned resident #1. It was resident #1's shower day so she went to ask the resident if she would like to shower, and the resident said yes. She recalled she told the resident she would be back in a little while to get her up. She explained she entered the room again after about an hour to get resident #1 up from the bed and noticed the resident had her four-wheel walker nearby, so she asked the resident if she was feeling strong enough to transfer without the mechanical lift. Resident #1 told her she was feeling well that day and agreed with CNA A to use her four-wheel walker and not the mechanical lift because she did not like using it. CNA A conveyed she then assisted the resident to sit up at the side of the bed and placed the walker in front of her as well as the wheelchair. Resident #1 stood up by holding on to the walker and CNA A assisted by standing next to her supporting her arm. Once resident #1 stood up she complained her knees were feeling heavy, and she could not keep standing. CNA A said she immediately moved behind the resident and assisted her to the floor as she fell sideways, twisting her left leg in the process. CNA A said she saw another CNA pass by the hallway and she screamed for help. She continued the resident was assessed and sent to the hospital because of pain to her left leg. She explained she knew resident #1 very well and had an understanding with her that if she was feeling strong, she would not use the mechanical lift. She said normally she would check the Kardex, which was in the resident's medical record and detailed the tasks assigned to the resident based on their care plan, but she only did that if the resident was new to her assignment. She acknowledged she knew resident#1 required two to three person staff assist with a mechanical lift because this was the way she had been transferred since her most recent admission to the facility. CNA A explained on the day of the incident she was surprised to see the walker in the room which led her to believe there had been a change in the resident's transfer status. She said that even after seeing the walker in the room, she did not confirm the transfer status in the Kardex but took the resident's word she was strong enough to transfer herself without the mechanical lift. She admitted that she had transferred the resident without assistance of the mechanical lift in the past because the resident disliked using it. CNA A said that looking back now she should have checked the Kardex and should have asked other staff for assistance with the transfer because it was her job to keep the resident safe.</p> <p>On 10/31/24 at 9:30 AM, the Director of Nursing (DON) and Administrator were interviewed jointly regarding resident #1's transfer status. They both agreed and acknowledged it was a therapy recommendation to have three people assist during transfers because the resident was severely, morbidly obese and totally dependent on staff for transfers. They explained the third person was an extra safety measure. The DON said that during morning Interdisciplinary Team (IDT) meetings they had previously discussed resident #1 and why it would be beneficial to have a third person during transfers. The third staff member would be in the room for support while the two others would be manning the mechanical lift. The Administrator stated that CNA A was aware of resident #1's transfer status and verified that in her statement. He said CNA A chose to honor the resident's wishes of not using the mechanical lift and failed to inform her immediate supervisor of the resident's refusal to use the mechanical lift as she was care planned for. Later at 10:30 AM, the DON said her expectation was for CNAs to check the Kardex at the beginning of their shifts. The DON explained she understood that staff got into a routine with their assigned residents, but confirmed they still needed to check the Kardex prior to caring for the residents at the beginning of their shifts because their status could change anytime. They explained the therapy department evaluated the residents' mobility and transfer status which was then communicated to the Care Plan coordinator and nursing staff. The care plan interventions were reflected in the Kardex for the CNAs to see. They stated that CNAs received mechanical lift training upon hire and then quarterly from the staff developer and risk managers.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On 10/31/24 at 11:00 AM, a joint interview was conducted with the Director of Rehabilitation and the Physical Therapist that evaluated resident #1. The Physical Therapist said she had been working with resident #1 since she was readmitted to the facility on [DATE]. She explained the resident's medical status constantly changed and she was frequently in and out of the hospital. This required frequent PT evaluations to determine her mobility and transfer status. They said resident #1 often refused PT and would refuse to get out of bed, which prevented them from evaluating her ability to transfer from the bed to the wheelchair. The times she did agree to receive PT, it would require two therapists to assist her with the use of a therapy provided walker, but she had severe difficulty ambulating. They said she was discharged from PT on 10/02/24 with the recommendation that a mechanical lift be used for transfers because the resident was non-compliant. They confirmed therapy felt she was not safe to transfer without the lift. She further added that the therapy department only made the recommendation for use of the mechanical lift, but the facility assigned how many people assisted based on the facility's policies and procedures. The Director of Rehabilitation confirmed the policy was to have two people assist with mechanical lift transfers. She further explained that once an evaluation had been made by the therapy department, they provided a communication sheet with their recommendations to the Care Plan Coordinator for the care plan to be created. She said that they communicated with the Unit Managers and CNAs. She explained regarding the four-wheel walker in the resident's room on the day of the incident, they were aware the resident had it but it was not used by therapists during therapy sessions. They confirmed therapy was not responsible for checking if the walker was adequate for use by the resident and there was no facility policy requiring the walker be evaluated since it was personal property. They both agreed that resident #1 was able to make her needs known and was aware she needed the mechanical lift for transfers due to her declining physical health.</p> <p>Review of CNA A's Skills Competency Assessment for Mechanical Lifts revealed that on 7/20/24 the assessment was completed as part of the annual required competencies. The assessment indicated CNA A was found to be competent to perform the task per the Risk Manager who was the evaluator. A review of the CNA's job description document dated March 2023, was signed as completed. The document revealed CNAs were responsible for observing safety needs of residents as indicated in their care plans and to follow established safety policies and procedures. Furthermore, they were to assist with lifting, positioning, and transporting residents into and out of bed, chairs, bathtubs, wheelchairs, and lifts per specific resident safety needs.</p> <p>The facility's policy on positioning and moving residents titled, Safe Lifting and Movement of Residents with review date of 1/25/23, read, Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' need for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. The facility also had a second policy entitled, Lifting Machine, Using a Portable, with revision date 1/25/23. This policy directed staff to review the resident's care plan to assess for any special needs of the resident and required two trained staff members when using the mechanical lift.</p> <p>Review of the Facility Assessment Tool updated 8/05/24 revealed that the services and care offered was based on resident needs which included mobility and fall/fall with injury prevention. The assessment further revealed that the facility would provide person-centered care and would identify any hazards and risks to the resident.</p> <p>The immediate actions to remove the Immediate Jeopardy by the facility were reviewed and revealed the following which was verified by the survey team:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>*On 10/11/24 at 12:50 PM, resident #1 was transferred to the hospital.</p> <p>*On 10/11/24 at 6:30 PM, the facility was made aware that resident #1 sustained a left fibular fracture.</p> <p>*On 10/11/24 CNA A was removed from her assignment, interviewed about the incident, and then suspended pending investigation. At 7:00 PM, law enforcement was notified and at 8:00 PM, they reported the incident to Department of Children and Families.</p> <p>*On 10/11/24 all staff were in-serviced on following care plans for transfers, how to access information on the Kardex, and following appropriate transfer status for each resident. All 85 CNAs were either trained in-person or via Onshift messaging by 10/13/24 and all 48 nurses were trained by 10/15/24. Observations of mechanical lift transfers were completed with CNA groups to ensure transfers were completed correctly.</p> <p>*On 10/12/24 the facility reviewed all residents who required a mechanical lift for transfers, those who were interviewable, were questioned to determine if the care plan was being followed.</p> <p>*On 10/12/24 all staff involved were interviewed and witness statements were taken. A review of CNA A's personnel file was completed to ensure there was education and competencies related to transfers and mechanical lifts present. Competencies had been completed in July 2023 and July 2024.</p> <p>*On 10/14/24 a Quality Assurance and Performance Improvement meeting was held to discuss the event and adequate follow up. The Medical Director, Administrator, DON, Risk Manager, and other department heads attended the meeting.</p> <p>*On 10/15/24 CNA A was terminated and reported to the Board of Nursing due to her not following resident #1's care plan for transfers and admitting she was aware the resident required a mechanical lift, and three person assist but chose to not follow the care plan.</p> <p>On 10/31/24 from 10:37 AM to 11:45 AM interviews were conducted with five CNAs, one Licensed Practical Nurse (LPN), and one Registered Nurse regarding transfers, locating resident transfer status, and education received after the incident. Two of the seven staff members were able to identify where they could find the resident's transfer status. The other five staff members stated that they would ask another staff member about the resident's transfer status, or they would ask the resident.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>An interview was conducted with the facility's Staffing Developer and Risk Manager on 10/31/24 at 12:08 PM. They stated that they had recently provided education and training for all staff to ensure all nursing staff knew where to find the resident's transfer status. They educated staff on the facility policy of having two staff members assist during transfers with mechanical lift. They explained that CNAs were told that they needed to report a resident's refusal to use the mechanical lift to their immediate supervisor and explain to the resident that they must follow the care plan to keep the. In addition, other education provided included demonstration of how to safely use the mechanical lift, how to check the Kardex at the beginning of their shift, and how to update the CNA shift report sheet that indicated the care needs, including transfer status, of their assigned residents. The Staffing Developer was made aware by the survey team that only two staff members out of seven were able to identify where they must look for the resident's transfer status. Following the interview, at around 3:20 PM, six CNAs and one LPN from the 3:00 PM-11:00 PM shift were interviewed and there were no issues with their answers.</p> <p>Review of the in-service attendance sheets validated mechanical lift education accompanied by competencies and post-test were completed on the topics of safe transferring with mechanical lifts, checking the Kardex for transfer status, and following the facility's policies on transfers. As of 10/31/24 about 94% of staff had received the education.</p> <p>The resident sample was expanded to include four additional residents who were identified as requiring a mechanical lift for transfers. Observations, interviews, and record reviews revealed no concerns with their care plans or staff assistance during transfers.</p> |   |  |