

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Waldorf Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4140 Old Washington Highway Waldorf, MD 20602	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>16177</p> <p>Based on interviews and record review, the facility failed to invite one of four residents (Resident (R) 41) reviewed for care planning out of a total sample of 31 residents to care plan meetings. This failure increased the risk that the resident would not have any direct input into his/her plan of care.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R41 was cognitively intact.</p> <p>Review of the EMR Clinical Resident Profile revealed R41's mother was listed as the care conference person.</p> <p>During an interview on 08/15/24 at 12:38 PM, R41 stated that his/her mother attended the care plan meetings but s/he did not but s/he would like to attend.</p> <p>Review of the EMR Progress Notes, dated 08/01/24, revealed R41's mother attended the care plan meeting, but the resident did not. The Progress Note documented a referral to the rehab department along with the resident's full code status were discussed with R41's mother.</p> <p>During an interview on 08/15/24 at 3:39 PM, the Social Services Coordinator (SSC) stated that family members and responsible parties were notified of upcoming care plan meeting via phone and letter and that alert and oriented residents were notified via a document with the time and day of the care plan meeting. When asked for the document informing R41 of the care plan meeting scheduled on 08/01/24, the SSC stated, [R41] is not competent [therefore his/her mother attends]. When informed that R41 scored 15 out of 15 on the BIMS, dated 07/25/24, the SSC stated she would have to check whether R41 was deemed incompetent to make healthcare decisions.</p> <p>During an interview on 08/15/24 at 5:46 PM, the Director of Nursing (DON) verified that competent residents are to be invited to their care plan meetings.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/16/24 at 5:54 PM, Social Services Assistant (SSA) provided a copy of a Physician Certifications Related to Medical Condition, Decision Making, and Treatment Limitations, dated 04/20/18, where a physician deemed R41 has adequate decision making capacity (including decisions about life-sustaining treatments). The SSA verified that R41 was competent and his/her own decision maker but was not invited to the care plan meeting.</p> <p>Policies on determining decision makers and care plan meetings were requested of the SSC but not provided by the time of survey exit.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>20243</p> <p>Based on observations, interviews, record review, and policy review, the facility failed to make preplanned menus and a list of alternative foods readily available to four of four residents (Resident (R) 31, R41, R50, and R101) reviewed for choices in a total sample of 42 residents resulting in the residents not having the opportunity to choose their meal or their choice of an alternative food prior to being served. This increased the risk of residents receiving foods not to their liking and being unaware of alternative food choices available to them.</p> <p>Findings include:</p> <p>1. During an interview on 08/13/24 at 12:19 PM, R101 stated that no one asked him/her what his/her preferences were for menu selection each day.</p> <p>Review of R101's electronic medical record (EMR) admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R101 had no cognitive impairment.</p> <p>R101's dietary preferences were requested, and nothing was received.</p> <p>During an observation on 08/15/24 at 8:15 AM, R101 received scrambled eggs, toast, jelly, apple juice, cereal, and milk. R101 stated that s/he would have preferred to have oatmeal. R101 confirmed that s/he had not received information regarding the menu and an opportunity to pre-select his/her preference.</p> <p>During an observation on 08/15/24 at 1:22 PM, R101 received a pork sandwich, corn, bean soup, and a fruit cup. R101 stated that s/he would have preferred to have had the Caesar salad. R101 confirmed s/he had not received information regarding the menu and an opportunity to pre-select his/her preference.</p> <p>During an interview on 08/15/24 at 2:48 PM the District Manager of Dietary (DM) stated the residents who have asked for more choices have been given menus from which to choose selections. DM stated these menus are given to the nursing department to ask residents to fill out and turn in. DM stated that there is no policy regarding this process that he knew of.</p> <p>During an interview on 08/16/24 at 9:39 AM, the Director of Nursing (DON) stated the facility did not have a policy regarding offering menus to the residents. The DON stated that on the weekend the nursing department took a menu for the upcoming week to residents and allowed them to pre-select and then turned it in to the dietary department.</p> <p>16177</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an interview on 08/13/24 at 3:06 PM, R31 stated that the facility staff did not obtain all of his/her food preferences and had no menu in his/her room to know what was being served to be able to choose. R31 stated s/he was not able to leave his/her room due to COVID and that no staff member brought a menu to him/her to choose his/her meals. R31 stated that if s/he did not like what was served to him/her, s/he would send it back to the kitchen. When asked if s/he would ask for the alternative, R31 stated s/he would not because s/he did not know what was available as an alternative other than a peanut butter sandwich.</p> <p>Observation on 08/13/24 at 3:06 PM of R31's room revealed no menus for R31 to choose his/her preference between the entree and the alternative.</p> <p>Review of the EMR Orders tab revealed a physician's order, dated 08/06/24, for strict isolation for COVID positive diagnosis and R31 was to remain in his/her room and all services, meals, recreation, and therapy were brought to his/her room.</p> <p>Review of the EMR admission MDS with an ARD of 03/25/24 revealed a BIMS score of 15 out of 15 indicating R31 was cognitively intact.</p> <p>Review of the undated Resident Likes Report revealed Brussel sprouts cooked five different ways was listed along with buttered rice, fiesta corn, mashed potatoes, and scrambled eggs with cheese. Review of the undated Resident Dislikes Report revealed cucumbers listed three different ways as his/her only dislike.</p> <p>Review of the Week-At-A-Glance menu, provided by the DM, revealed 08/16/24 oatmeal, pancakes, and sausage links were listed for breakfast. Scrambled eggs were not listed.</p> <p>During an observation and interview on 08/16/24 at 9:00 AM, R31 was observed eating his/her breakfast in his/her room. Review of his/her tray ticket revealed oatmeal was listed as provided but R31 did not receive the oatmeal. Scrambled eggs were on the tray ticket and provided although not listed on the menu.</p> <p>On 08/16/24 at 9:10 AM, Geriatric Nurse Aide (GNA) 1 stated that she did take the menu to her residents that morning for them to choose. On 08/16/24 at 9:10 AM, R31 verified that GNA1 did provide the menu to him/her that morning but that no staff provided menus while s/he was in isolation for 10 days.</p> <p>3. During an interview on 08/13/24 at 9:34 AM, R41 stated that the dietary staff did not follow his/her preferences and that s/he was not provided a menu to be able to choose what s/he would like for breakfast, lunch, or dinner unless s/he ate his/her meals in the dining room. R41 stated that s/he required a mechanical lift to be transferred from bed to a wheelchair and that s/he did not get out of bed for each meal every day.</p> <p>An observation on 08/13/24 at 9:34 AM of R41's room revealed no menus for R41 to choose his/her preference between the entree and the alternative.</p> <p>Review of the EMR quarterly MDS with an ARD of 07/25/24 revealed a BIMS score of 15 out of 15 indicating R41 had intact cognition and was totally dependent on staff for transfers from the bed to a wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the undated Resident Dislikes Report, provided by the District Dietary Manager (DM), revealed Turkey Group as the only dislike listed. Review of the undated Resident Likes Report, provided by the DM, revealed no foods were listed.</p> <p>Review of the EMR Care Plan tab revealed a care plan for nutritional risk with an intervention to honor food preferences within the meal plan and honor the right to choose cultural food preferences.</p> <p>During an interview on 08/15/24 at 1:15 PM, R41 stated s/he had gone to the dining room and was able to choose his/her lunch meal and was satisfied with the meal.</p> <p>During an interview and observation on 08/16/24 at 9:03 AM, R41 was in bed and finishing his breakfast meal eating a sausage link. Review of the tray ticket, dated 08/16/24, revealed sausage was not listed on the ticket. Further review of the tray ticket revealed oatmeal, pancakes, and scrambled eggs listed for breakfast. R41 verified that s/he had not chosen his/her breakfast meal from the menu.</p> <p>Review of the Week-At-A-Glance menu, provided by the DM, revealed oatmeal, pancakes, and sausage links for breakfast on 08/16/24. Scrambled eggs were not listed.</p> <p>4. During an observation on 08/16/24 at 9:05 AM, R50 was being fed a pureed meal by GNA2. Review of R50's breakfast tray ticket stated oatmeal, fruit juice, pureed pancakes with diet syrup and margarine, scrambled eggs, 2% milk assorted beverage, jelly with bread, and pureed sausage were provided. The pureed sausage looked like pureed ham and there were no scrambled eggs on R50's tray. GNA2 verified the missing items on R50's breakfast tray. GNA2 verified that she did not provide a menu or ask the residents what they would like to choose for their meals.</p> <p>During an interview on 08/16/24 at 9:42 AM, the [NAME] (C) 1 verified that the pureed meat was ham and not sausage for the breakfast meal. C1 stated that the kitchen did not have the loose sausage but only sausage links. C1 stated that pureed sausage was prepared with loose sausage.</p> <p>Review of the EMR quarterly MDS with an ARD of 05/04/24 revealed R50 was severely impaired cognitively and dependent on staff for eating.</p> <p>R50's dislikes and likes were not provided before exit of the survey on 08/16/24.</p> <p>Review of the EMR Care Plan tab revealed a care plan, revised on 11/16/22 for nutritional risk with an intervention to honor food preferences within the meal plan.</p> <p>During an interview on 08/14/24 at 11:50 AM, the DM stated that the menus were posted in each hall and near the dining room. When the DM was asked how residents who could not or did not want to leave their room know what the menu is, the DM stated that nursing and dietary were to take the menu to each room and ask each resident their preference. The DM stated he was not sure if this was occurring.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/15/24 at 8:48 AM, the DM stated that the menus were preference based. The DM stated that resident food preferences were determined on admission to the facility by nursing and dietary staff. The DM stated that the menu program defaulted to the alternative if the entree was not a preference listed. If the entree was listed as a food preference, then that was what the resident was served. The resident did not have a choice if the entree and the alternative were both food likes. If neither the entree nor alternative were listed as food preferences, then dietary would choose and send an alternative.</p> <p>During an interview on 08/16/24 at 3:18 PM, the DON confirmed that the nursing staff were to take the menu for breakfast, lunch, and dinner each morning and ask the resident what they wanted for each meal and then provide that information to the dietary staff.</p> <p>Policies on menu distribution, resident choice and food preferences were requested but not provided before the survey exit on 08/16/24.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>36917</p> <p>Based on interview and record review, the facility failed to act promptly to the concerns and requests of the resident council to receive meal menus and to consider their preferences for food choices. Five residents (Resident (R)11, R12, R56, R63, and R72) who regularly attended resident council expressed that their concerns had repeatedly been unresolved and unanswered.</p> <p>Findings include:</p> <p>During a group interview on 08/17/24 at 3:00 PM with five residents (R11, R12, R56, R63, and R72) in attendance, they reported they have requested a meal menu each week for selecting their food choices and for their food preferences to be considered. The residents expressed they did not receive a rationale for their requests not being received. Each resident attending the group meeting was listed on previous month's resident council meeting notes list of attendees. The group of residents indicated they reported the same concerns at every monthly meeting but did not receive an explanation or resolution to their concerns and continued complaints. During the interview, R11 stated they did not receive meal menus with the opportunity to select menu item preferences. R12 stated the dietary manager previously made menus available to select food choices of the day, but the choices selected were never served on their tray. R56 said we tell them we want oatmeal, but they just don't hear us.</p> <p>Review of the resident council meeting notes provided by the facility:</p> <p>-On 01/24/24, as documented by the Activity Manager (AM), revealed a grievance/concern that meal menus were no longer being provided and that breakfast food choices for oatmeal were not being considered or honored. The AM documented in the notes the action that would be taken by the dietary department staff to provide menus and breakfast meal choices to include oatmeal, and that menus would be provided to residents on Friday of each week for the following week menu changes by the AM.</p> <p>-On 02/28/24, documented meal menu choices were not being received. The AM documented that action would be taken to survey all residents on all units for meal preferences and that all staff would receive in-service training regarding resident rights.</p> <p>-On 05/22/24, documented no menus had been provided to residents and that food preferences were still not being honored and no resolution by the facility was documented.</p> <p>-On 07/24/24, the AM documented no menus were available to residents and that food preferences were not being honored. The AM documented to resolve the issue by asking the dietary manager to partake in a mock plate and be included in conversations between the residents and the dietary staff. There was no indication the proposed resolution had been acted upon.</p> <p>During an interview on 08/15/24 at 3:46 PM, the AM stated he was aware of the residents' request to receive meal menus and food preference forms. The stated he had spoken with the District Dietary Manager (DM) and that the dietary department was working on getting menus and meal choices honored for the residents. The AM could not provide documentation that he had communicated the resident concerns and grievances regarding meal menus and food preferences as discussed in the resident council monthly meetings.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/16/24 at 1:36 PM, the DM stated that the dietary department was in the process of making changes and that he was aware of the concerns and grievances from residents regarding meal menu availability and food preferences but had not followed up on the mock plate discussion for resolution</p> <p>During an interview on 08/18/24 at 10:46 AM, the Administrator stated her expectation of dietary staff was that they considered the views of the resident council group concerning issues of life in the facility and that staff needed to demonstrate their response and rationale for their response to honor resident concerns regarding meal menus and food choices. The Administrator stated she was aware that food menus were not available to the residents but had not followed up with the residents' request for meal menus and food preferences not being honored. She said she knew the importance of considering and honoring resident requests and following up on grievances from the resident council group.</p> <p>The facility did not have a policy that addressed responding to resident group concerns.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145</p> <p>Based on record review, observation of resident rooms, equipment, and interviews, it was determined the facility staff failed to 1.) provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, this was evident on 2 of 3 nursing units observed along with the dining room; and 2.) failed to exercise reasonable care for protecting one supplemental resident's (Resident (R)169) personal property from loss or theft.</p> <p>The findings include:</p> <p>1.) On [DATE] at 10:58 AM observation was made of room [ROOM NUMBER]. The left wall by the door entrance had a large, spackled area that was not painted over that was at least 2 ,d+[DATE] ft. by 3 ft. The laminate was peeling off the 4 dresser drawers. The handrail in the bathroom had brown material and brown drip marks near the front of the handrail by the door approximately 5 inches long.</p> <p>On [DATE] at 11:06 AM observation was made of room [ROOM NUMBER]. The privacy curtain was stained with brown and black material. The floor was dirty with debris and a soiled plastic glove was on the floor by the end of the bed. At that time Certified Medicine Aide (CMA) #3 walked in the room and was asked what she does when she sees something in disrepair. CMA #3 stated she will put it in the TELS system (electronic system) and then ask the Geriatric Nursing Assistants) GNAs if they have any repair orders. CMA #3 was shown the areas of concern.</p> <p>On [DATE] at 12:40 PM observation was made in the dining room of Resident #12 sitting in a wheelchair. The right wheelchair armrest was missing the underneath padding. The left wheelchair armrest vinyl covering was torn along the outer and inner edge, exposing the underneath padding.</p> <p>Resident #53 was also observed in the dining room sitting in a wheelchair. The right and left vinyl on the armrests of the wheelchair were cracked throughout the armrest. Resident #5 was observed sitting in a wheelchair. The vinyl on the right armrest was torn at the front with foam exposed and the vinyl was also cracked throughout the armrest.</p> <p>On [DATE] at 12:42 PM Staff #12, Maintenance Director was interviewed in the dining room as he was shown the wheelchair armrests. Staff #12 stated that he audits wheelchairs every 2 months and had replacement armrests that he could put on the chairs.</p> <p>On [DATE] at 2:28 PM observation was made in room [ROOM NUMBER] of the nightstand. The top drawer in the right-hand corner was missing laminate. The bottom cabinet drawer below the handle was missing laminate approximately 4 inches by 4 inches.</p> <p>On [DATE] at 2:35 PM the Nursing Home Administrator (NHA) was informed of the furniture observations which included the wheelchairs. The NHA stated, when I got here in July, I did a furniture audit, and the order was approved yesterday. Maybe it was pushed along because the surveyors are in the building. I also hired a painter for the rooms. The surveyor also requested the most recent invoices for the wheelchair armrests. The NHA could not provide the invoices.</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>16177</p> <p>Based on interview and record review, the facility failed to provide a written notice of transfer to the resident or family/representative for one of three residents (Resident (R) 471) reviewed for hospitalization s of 31 sampled residents. This failure had the potential for the residents or their representatives to lack the knowledge of where and why they were transferred and how to appeal the transfer if desired.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/22/23 revealed R471 was severely impaired cognitively and dependent on all Activities of Daily Living (ADLs) except eating.</p> <p>Review of the EMR Progress Notes tab revealed a nurse's note, dated 10/07/23, stating R471 was found with his/her head against the side rail and bleeding from the forehead. The progress note stated after the nursing staff provided first aid it was determined that R471 had a laceration on his/her forehead from either the side rail or the resident's long jagged fingernails. According to the progress note, R471 stated he/she had rolled over and hit his/her head on the side rail causing the laceration. The facility sent R471 out via ambulance to the emergency room for further evaluation. The resident underwent a computed tomography (CT, medical imaging technique to create detailed pictures inside the body scan of the head/brain/spine with no abnormalities shown. The resident was not admitted to the hospital but returned to the facility.</p> <p>Review of the EMR Progress Notes, Documents, and Assessments, and the entire hard chart revealed no written notification of transfer was provided to the family.</p> <p>During an interview on 08/16/24 at 1:20 PM, the Administrator stated that the facility had not been providing written notification of transfer to the residents and/or representatives.</p>		

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NAME OF PROVIDER OR SUPPLIER Waldorf Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4140 Old Washington Highway Waldorf, MD 20602	
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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36917</p> <p>Based on interview and record review, the facility failed to ensure an accurate pre-admission screening and resident review (PASARR) Level II of a resident for a mental disorder (MD) or intellectual disability (ID) was utilized for one of five residents (Resident (R) 81) reviewed for PASARR. The failure to ensure R81 received a Level two PASARR evaluation for MD/ID or a related condition, could prevent the resident from attaining or maintaining his/her highest practicable level or result in a decline in the resident's physical, mental or psychosocial well-being.</p> <p>Findings include:</p> <p>Review of R81's undated Admission Record, located in R81's electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] and diagnoses included but not limited to: moderate intellectual disabilities, bipolar disorder, schizoaffective disorder, unspecified psychosis, and anxiety disorder.</p> <p>Review of R81's annual "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of 06/06/24 revealed R81 had a "Brief Interview for Mental Status (BIMS)" score of six out of 15, which indicated s/he was moderately cognitively impaired. The MDS indicated R81 had moderate intellectual disabilities.</p> <p>Review of R81's EMR Miscellaneous tab, indicated a Level I PASARR form dated 04/06/23, with an exempted hospital discharge screening that required notification to the State Authority for a Level II evaluation if resident remained in the facility for 40 or more days.</p> <p>Review of R81's care plan located in the EMR under the "Care Plan" tab with a revised date of 05/06/24, focused on R81's impulsive behaviors related to psychiatric disorders as evidenced by requesting multiple food trays, compulsive requests for writing paper, stamps, envelopes, tape, glue, stuffing writing paper in the toilet, banging the food truck with requests for additional food, yelling at staff when s/he is redirected, taking food off trays on the food cart, and taking food out of the refrigerators within his/her reach. R81's care plan also documented s/he had impaired communication as evidenced by stuttering and impaired speech articulation.</p> <p>During an interview on 08/15/24 at 1:12 PM, the Social Worker (SW) confirmed R81 was admitted to the facility on [DATE] with a PASARR Level one hospital discharge exemption but the facility staff failed to request a PASARR Level two screening by the State Agency (SA) after R81 remained in the facility longer than 40 days.</p> <p>During an interview on 08/15/24 at 4:41 PM, the Administrator confirmed R81 did not have a PASARR Level II as required after R81 was in the facility for more than 40 days. He stated that the facility should follow the Centers for Medicare and Medicaid Services (CMS) guidelines for PASARR and that the facility did not have a policy related to PASARR.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>16177</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide nail care to two of four residents (Resident (R) 1 and R41) reviewed for activities of daily living (ADLs) out of a total sample of 31 residents. This failure increased the risk for scratches to the skin which increased the risk of skin breakdown and infection.</p> <p>Findings include:</p> <p>1. Review of R1's electronic medical record (EMR) revealed an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/24. Further review of this MDS revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R1 was cognitively intact but totally dependent on staff for all ADLs.</p> <p>Review of the EMR Care Plan tab revealed a care plan, revised on 02/25/24, Resident/Patient requires dependent for ADL care in; bathing, grooming, personal hygiene . related to MS [Multiple Sclerosis], functional quadriplegia [paralysis of arms and leg] . Residents/ Patients ADL care needs will be anticipated and met throughout the next review period .</p> <p>During an observation on 08/13/24 at 4:27 PM, R1's fingernails on both hands were half an inch long and soiled with a black substance.</p> <p>During an observation and interview on 08/15/24 at 11:09 AM, R1's fingernails on both hands remained half an inch long and soiled. R1 shook his/her head no when asked if s/he wanted his fingernails long.</p> <p>During an interview on 08/15/25 at 1:00 PM, Licensed Practical Nurse (LPN) 1, who was also the Unit Manager, verified that R1's fingernails were long and soiled. LPN1 was asked who was responsible for nail care, she stated the Geriatric Nursing Aides (GNAs) were responsible, and the task was on the GNA Plan of Care that was to be followed for each resident.</p> <p>During an observation and interview on 08/15/24 at 4:56 PM, LPN4 verified that R1's nails were long and soiled.</p> <p>During an observation and interview on 08/16/24 at 11:11 AM, R1's fingernails had been trimmed and cleaned. When asked if s/he was pleased with the length of his/her fingernails, R1 nodded yes.</p> <p>2. Review of the EMR quarterly MDS with an ARD of 07/25/24 revealed a BIMS score of 15 out of 15 indicating R41 was cognitively intact but dependent on staff for all ADLS.</p> <p>Review of the EMR Care Plan tab revealed a care plan, revised on 11/05/21, for Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene . related to: Limited mobility . Provide resident total assist of 1 [sic] for personal hygiene (grooming).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 08/13/24 at 9:26 AM, R41 had half to one inch long soiled fingernails on both hands. R41 stated it was frustrating because s/he did not like his fingernails to be long.</p> <p>During an observation on 08/15/24 at 10:46 AM, R41's fingernails remained long and soiled.</p> <p>During an observation and interview on 08/15/24 at 4:36 PM, LPN4 verified that R41's fingernails were long and soiled.</p> <p>During an observation and interview on 08/16/24 at 9:59 AM, R41's fingernails had been trimmed and cleaned. R41 stated s/he was pleased that his/her fingernails had been trimmed.</p> <p>During an interview on 08/16/24 at 3:18 PM, the Director of Nursing (DON) verified that the GNAs were responsible for nail care during the showers/baths provided to the residents.</p> <p>A policy for ADL care was requested but not provided by the facility prior to exit on 08/16/24.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>16177</p> <p>Based on observations, record review, interviews, and policy review, the facility failed to consistently apply a hand splint ordered to prevent further contractures (deformity of a joint or joints due to the shortening of muscles and/or tendons) in one of seven residents (Resident (R) 72) reviewed for positioning and mobility in a total sample of 31 residents. This failure increased the risk of further loss of mobility and increased contractures.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R72 was cognitively intact. Further review of this MDS revealed R72 had impaired range of motion of the left upper extremity.</p> <p>Review of the Orders tab of the EMR revealed a physician's order dated 12/10/23 for a left hand roll splint to be worn for four consecutive hours during day shift. Further review of the Orders tab revealed an order dated 03/29/23 for Occupational Therapy splinting and contracture management, patient and staff education and training, and discharge planning.</p> <p>Review of the Care Plan tab of the EMR revealed a care plan titled, Restorative Splint Assistance: Patient cannot apply and remove left hand splint to prevent further functional deterioration, revised on 05/12/24, for left hand roll splint to be worn for 4 consecutive hours during the day shift .</p> <p>During an observation on 08/14/24 at 9:50 AM, R72 was observed in his/her wheelchair with no hand splint on his/her left hand. During this observation, R72 stated that s/he did not know where the splint was, that s/he could not put it on his/herself, that it did not cause pain, and that the staff had not put the splint on for a long time. R72 was asked to open his/her hand but could only open it by extending the fingers of his/her left hand with the fingers from his/her right hand.</p> <p>During an observation on 08/14/24 at 10:19 AM and 12:00 PM, R72 was observed without the left hand splint in place. On 08/14/24 at 12:00 PM, Geriatric Nurse Aide (GNA) 1, who was caring for R72, stated she was not aware that R72 had an order for a splint and did not know where the splint was.</p> <p>During an interview on 08/14/24 at 12:00 PM, GNA1 and Licensed Practical Nurse (LPN) 1, who was the Unit Manager, verified that R72 did not have a splint on his/her left hand. Both GNA1 and LPN1 verified that the order for the splint was located on the Plan of Care (POC) followed by the GNAs.</p> <p>During an observation on 08/15/24 at 12:35 PM, R72 was observed with no hand splint on his/her left hand.</p> <p>Further review of the EMR Orders tab revealed a physician's order dated 08/14/24 to refer to the rehabilitation department for a hand splint.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Waldorf Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4140 Old Washington Highway Waldorf, MD 20602	

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/16/24 at 9:07 AM, the Director of Rehab (DOR) stated that staff could not find the splint and therefore R72 was reevaluated by therapy for a splint for the left hand. The DOR stated that once a resident was discharged from therapy, restorative nursing was the responsibility of the nursing staff. The DOR provided a restorative nursing plan dated 09/28/23 for the left hand roll splint to be worn four consecutive hours from 9:00 AM to 1:00 PM and to contact therapy if problems arise with skin integrity, proper fit, or non-compliance with wearing schedule.</p> <p>During an interview on 08/15/24 at 5:46 PM, the Director of Nursing (DON) verified that the nursing staff, in particular the GNAs, were responsible for implementing the restorative nursing care plan interventions including splints.</p> <p>Review of the policy titled, Restorative Nursing, revised 08/07/23, revealed Centers may provide restorative nursing programs for patients who: . have restorative needs arise during the course of a longer term stay . Restorative programs are coordinated by nursing or in collaboration with rehabilitation . A licensed nurse must supervise the activities in a restorative nursing program .implement the restorative nursing program according to the specifics on the care plan .</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177</p> <p>Based on record review, interviews, and policy review, the pharmacist failed to identify that adverse consequences and target behaviors were not identified or monitored for one of five residents (Resident (R) 107) reviewed for unnecessary medications out of a total sample of 31 residents. This failure increased the risk of residents receiving an antipsychotic medications without proper monitoring.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/24 revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating R107 was severely cognitively impaired. Further review of this MDS revealed R107 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and Parkinsonism with no hallucinations, delusions, or verbal or physical behaviors towards self or others.</p> <p>Review of the EMR Orders tab revealed a physician's order, dated 07/22/24, for Seroquel (antipsychotic) 12.5 milligrams once a day for the target behavior of agitation.</p> <p>Review of the Prescribing Information for Seroquel retrieved from www.accessdata.fda.gov revealed Seroquel was an atypical antipsychotic medication indicated to treat schizophrenia and bipolar disorder. Further review revealed, Seroquel carried a [NAME] of increased mortality in elderly patients with dementia.</p> <p>Review of the EMR Medication Administration Record (MAR), Treatment Administration Record (TAR), Tasks, and Progress Notes revealed no consistent monitoring of the target behavior of agitation or adverse consequences of taking Seroquel especially with a diagnosis of Alzheimer's dementia. Seroquel is an antipsychotic medication used to treat serious mental illness such as bipolar disorder and schizophrenia. Seroquel use in the elderly with dementia has the potential for serious adverse consequences that could result in death.</p> <p>Review of the EMR Assessment tab revealed a Medication Regimen Review (MRR), dated 08/12/24, with a recommendation for a Lidocaine patch to be discontinued due to nonuse. Further review revealed no recommendation by the pharmacist concerning the use of Seroquel for agitation and failure to monitor for adverse consequences and target behaviors for efficacy.</p> <p>Interview via telephone on 08/16/24 at 12:51 PM revealed the Pharmacist no longer had his computer database and could provide no information for specific residents.</p> <p>Review of the policy titled, Medication Monitoring, Medication Management dated 01/2024, revealed The attending physician in collaboration with the consultant pharmacist must re-evaluate the use of the psychotropic medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission. when monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medication as well as look for potential adverse consequences</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177</p> <p>Based on record review, interview, observation, and policy review, the facility failed to identify and monitor potential adverse consequences and target behaviors for one of five residents (Resident (R) 107) reviewed for unnecessary medications out of a total sample of 31 residents. This failure increased the risk of residents receiving antipsychotic medication without proper monitoring.</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/28/24 revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating R107 was severely cognitively impaired. Further review of this MDS revealed R107 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and Parkinsonism with no hallucinations, delusions, or verbal or physical behaviors towards self or others.</p> <p>Review of the EMR Orders tab revealed a physician's order, dated 07/22/24, for Seroquel (antipsychotic) 12.5 milligrams once a day for the target behavior of agitation.</p> <p>Review of the Prescribing Information for Seroquel retrieved from www.accessdata.fda.gov revealed Seroquel was an atypical antipsychotic medication indicated to treat schizophrenia and bipolar disorder. Further review revealed, Seroquel carried a [NAME] of increased mortality in elderly patients with dementia.</p> <p>Review of the EMR Care Plan tab revealed a care plan for complications related to the use of psychotropic drugs, initiated 08/12/24, with a goal of the smallest most effective dose without side effects with interventions including to monitor for continued need of medication as related to behavior and mood and to monitor for side effects. Further review of this care plan revealed no specific side effects or target behaviors to monitor. The Care Plan tab revealed no care plan for nonpharmacological interventions to use before using an antipsychotic medication.</p> <p>Review of the EMR Medication Administration Record (MAR), Treatment Administration Record (TAR), Tasks, and Progress Notes revealed no consistent monitoring of the target behavior of agitation or adverse consequences of taking Seroquel especially with a diagnosis of Alzheimer's dementia.</p> <p>Observations on 08/13/24 at 10:33 AM and on 08/15/24 at 4:00 PM revealed R107 to be resting in bed and participating in speech therapy, respectively, with Family Member (F) 1 in attendance. R107 was calm and in no distress during these observations. Interview on 08/15/24 at 4:20 PM, F1 stated that R107 did not appear in distress or agitated while she visited. F1 stated that she was with R107 from early in the morning until after dinner.</p> <p>During an interview on 08/15/24 at 4:09 PM, Speech Language Pathologist (SLP) 1 stated that R107 was not agitated during therapy.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/15/24 at 4:30 PM, the Unit Manager (UM) stated that R107 did not display agitation.</p> <p>During an interview on 08/16/24 at 3:18 PM, the Director of Nursing (DON) verified that no specific adverse side effects or behaviors were being monitored along with the use of Seroquel.</p> <p>Review of the policy titled, Medication Monitoring Medication Management, dated 01/2024, revealed . the clinical record must reflect the following: Whether there is adequate monitoring for the effectiveness of the medication in treating the specific condition and for any adverse consequences resulting from the medication</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30347</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to ensure kitchen staff properly cleaned food preparation equipment for use and that clean pans were air dried prior to storage. These failures had the potential to increase the risk of foodborne illness and had the potential to affect 103 of 110 residents (seven residents received nutrition via tube feedings with some pleasure foods allowed) in the facility who received dietary services.</p> <p>Findings include:</p> <p>1. During an observation and interview on 08/13/24 at 9:10 AM, the Account Manager Dietary (AMD) confirmed the meat slicer blade had food remnants on it and needed to be cleaned before it was used.</p> <p>During an interview on 08/13/24 at 9:10 AM, the AMD stated, it's my expectation that . the meat slicer be properly cleaned after each use, it should not have food left on it</p> <p>Review of the facility's policy titled, Equipment, dated 09/2017, revealed, Policy Statement: All food service equipment will be clean, sanitary, and in proper working order. Procedures: 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials . 3. All food contact equipment will be cleaned and sanitized after each use .</p> <p>2. During an observation and interview on 08/13/24 at 9:12 AM, the AMD confirmed three pans 12 inches by 24 inches by 2 inches deep, one pan 12 inches by 12 inches by 4 inches deep, two pans 6 inches by 12 inches by 3 inches deep, cleaned and stacked ready for use were still wet when they were unstacked. The pans were found to have been stacked wet and not allowed to air dry. The AMD stated, they should be dry before they are put away, they are supposed to air dry before stacking.</p> <p>Review of the facility's policy titled, Manual Ware Washing, dated 10/2022, revealed, Policy Statement: All cookware, dishware, and service that is not processed through the dish machine will be manually washed and sanitized. Procedures . 3. All service ware and cookware will be air dried prior to storage.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>30347</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure garbage was properly disposed of and contained in one of one dumpster areas which would affect 110 census residents and staff in the facility. This failure had the potential to attract pests.</p> <p>Findings include:</p> <p>Observation on 08/13/24 at 9:35 AM, with the Account Manager Dietary (AMD) of the area in the parking lot, behind the building where the trash dumpsters were located, revealed one of two dumpsters used to contain the facility trash and recycling material were open. The top lid was left open. There was a large trash bag lying on the ground between the two dumpsters that had been ripped open.</p> <p>During an interview on 08/13/24 at 9:35 AM, the AMD stated, The dumpsters should be closed, and bags of trash should be placed inside the dumpsters and not left on the ground.</p> <p>Review of the facility's policy titled, Environment, dated 09/2017, revealed Policy Statement: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition . 6. All trash will be contained in covered leak-proof containers that prevent cross contamination. 7. All trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Waldorf Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4140 Old Washington Highway Waldorf, MD 20602	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>16177</p> <p>Based on observations, interviews, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to follow infection control measures while caring for two of three residents (Resident (R) 31 and R1) reviewed for infection control out of a total sample of 31 residents. These failures increased the risk of COVID transmission and cross contamination during care for a resident on Enhanced Barrier Precautions.</p> <p>Findings include:</p> <p>1. Review of R31's electronic medical record (EMR) Orders tab revealed a physician order, dated 08/06/24, for Strict isolation, droplet precaution due to Covid positive diagnosis.</p> <p>During an interview and observation on 08/13/24 at 3:06 PM, Licensed Practical Nurse (LPN) 3 was observed performing wound treatment on R31's right lower leg. R31 stated s/he was not able to leave his/her room due to being positive for COVID. LPN3 was observed to finish the wound treatment, doff (take off) her Personal Protective Equipment (PPE) including gloves and place the PPE in a trash container inside R31's room. LPN3 then left the room without sanitizing or washing her hands. LPN3 was observed to walk down the hall to use a hand sanitizer dispenser attached to the wall close to the nurses' station. LPN3 was asked why she did not use the sanitizer in R31's room. LPN3 stated the sanitizer dispenser in R31's room was not working. LPN3 verified that she did not wash her hands before leaving R31's room.</p> <p>During an interview on 08/16/24 at 4:24 PM, the Infection Preventionist (IP) verified hand hygiene was expected to take place before leaving R31's room.</p> <p>2. During an observation on 08/14/24 at 9:00 AM, Geriatric Nurse Aide (GNA) 4 was observed leaving R31's room with two plastic bags one with trash and the other with soiled laundry. GNA4 was observed to place both bags on the carpeted floor of the hallway in front of R31's room. GNA4 then took the trash to the soiled utility room. GNA4 exited the soiled utility room and picked up the bag of soiled laundry and dropped it into a laundry bin as a laundry worker walked past R31's door. GNA4 was asked if there was no trash bin in R31's room and she stated she did not see it at the time and brought the trash down the hall to the soiled utility room.</p> <p>Interview on 08/14/24 at 12:15 PM, GNA4 verified that she had not labelled the bag of laundry from R31's room.</p> <p>During an interview on 08/15/24 at 11:24 AM, Laundry Worker (LW) 1 stated that the linen and personal clothing of residents positive with COVID were to be bagged and labelled so that laundry staff would know to wash them separately from the other residents' linens and personal clothes. LW1 stated when she arrived for her shift at 11:00 AM all the laundry had been washed together by the previous laundry worker.</p> <p>During an interview on 08/16/24 at 4:24 PM, the IP verified that the R31's trash should have been disposed of in the resident's room and not carried down the hall to the soiled utility room and that R31's soiled laundry should have been labeled for laundry to wash separately.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During observation of R1's wound care on 08/16/24 from 10:20 AM through 10:35 AM, LPN4 was observed to change her gloves three different times without sanitizing her hands between glove changes. LPN4 was observed to go from different wounds without sanitizing her hands after glove changes and touching the dresser and bed rails without sanitizing her hands after glove changes. During an interview on 08/16/24 at 10:38 AM, LPN4 verified she did not sanitize her hands between each glove change. During an interview on 08/16/24 at 10:40 AM, LPN1, who was assisting with positioning R1 during the wound care, verified that LPN4 did not sanitize between each glove change. R1 was on Enhanced Barrier Precautions due to having a feeding tube, urinary catheter, and nonhealing pressure ulcers.</p> <p>During an interview on 08/16/24 at 4:24 PM, the IP verified hand hygiene was expected between all glove changes.</p> <p>Review of CDC Clinical Safety: Hand Hygiene for Healthcare Workers, retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety revealed hand hygiene is necessary: before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal.</p>		