STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46252 Based on facility policy review, medical record review, facility investigation review, hospital record review, and interview, the facility failed to provide adequate supervision and assistance to prevent a fall accident for 1 of 3 residents (Resident #1) reviewed for accidents. On 1/21/25, Certified Nursing Assistant (CNA) V attempted to transfer Resident #1 from a shower bed to Resident #1's bed without assistance from another staff member and failed to lock all the shower bed wheels properly. Resident #1 fell between the beds and sustained an acute mildly displaced (pieces of bone moved so much that a gap formed when the bone broke) fracture (a partial or complete break in the bone) involving the left humeral neck (part of the long bone in the upper arm that connects the head with the shaft of the bone) with adjacent (next to the broken bone) soft tissue swelling (localized inflammation in the body's soft tissues, such as muscles, tendons, and ligaments), bruises on front side of chest, front and back of upper left arm, left elbow, left hip, and both ankles, resulting in Actual HARM to Resident #1. The Findings Include: 1. Review of the facility policy titled, Occurrence Reporting, revised 12/1/2022, revealed .Our facility must strive to provide a safe environment with methods to reduce accidents and methods to minimize injury from accidents .examples accidents/incidents .Falls .Bruises .Fracture .All observed, reported, or other acquired knowledge of an occurrence must be reported to the charge nurse or DON [Director of Nursing] by the employee who finds witnesses the incident .The Charge nurse shall complete the Event Note assessment completely .Notifying the primary provider .Responsible party .A new appropriate intervention .Shall be initiated .The charge nurse shall complete staff education as needed on the intervention put in place .The charge Nurse shall update the fall risk assessment if the event was a fall .The resident shall be observed for a minimum of 72 hours and document observations every shift . Review of the facility policy titled, Resident Rights and Resident Responsibilities, revised 11/20/2023, revealed, .The right to reside and receive services in the facility with reasonable accommodation of resident needs .Safe environment. The resident has a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and supports for daily living safely . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Accidents and Supervision, revised 9/5/2024, revealed, .The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents .Supervision/Adequate Supervision refers to intervention and means of mitigating risk of an accident .All staff .are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident .Implementation of Interventions-using specific interventions to try to reduce a resident's risks .Supervision is an intervention and a means of mitigating accident risk. The facility shall provide adequate supervision to prevent accidents . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Acute on Chronic Diastolic (Congestive) Heart failure (chronic condition in which the heart doesn't pump blood as well as it should), Acute on Chronic Combined Systolic and Diastolic Heart Failure (problems where the heart doesn't contract and relax effectively), Type 2 Diabetes Mellitus, Non-Ischemic Myocardial Injury (damage to the heart muscle), Acute Respiratory Failure with Hypoxia, Muscle Weakness (Generalized), Abnormalities of Gate and Mobility, Mild Intellectual Disabilities, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had problems with short-term and long-term memory, altered mental status, was moderately Impaired with decision making, and was rarely/never understood. Resident #1's language was Arabic with an interpreter needed to communicate with health care providers. Resident #1 was unable to provide the effort to complete ADLs. Resident #1 was dependent on staff to provide all the effort with the assistance of 2 or more staff required to complete the ADL activities of transfers, bed mobility, shower/bathe self, personal hygiene, and dressing. Resident #1 was always incontinent of bowel and bladder and had active diagnoses with medically complex conditions. Review of the section titled staff assessment for pain with indicators of possible pain in the last 5 days revealed .Non-verbal sounds .e.g. [for example] crying, whining, gasping, moaning, or groaning .Facial expressions .e.g. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw .Protective body movements or postures .e.g. bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement .Frequency of Indicator of Pain or Possible pain in the last 5 days .Indicators of pain or possible pain observed daily . Review of Resident #1's care plan with a revision date of 12/31/2024, revealed .At risk for impaired skin integrity .Use caution during transfers and bed mobility .Monitor for discoloring, bruises .At risk for bleeding/bruise R/T [related to] anticoagulant and antiplatelet .Monitor signs of bleeding .bruising .Implement safety precautions such as fall management protocols .Use extra caution with manually transferring or positioning .Check for new bruising/bleeding with ADL [Activities of Daily Living] care .Pain management . Assess location, intensity, duration, precipitating factors, and character of pain .Cognitive loss . Alteration and thought process .At risk for falls .Provide reminders to use .transfer assist devices .Impaired expressive/receptive communication related to cognition . Does not speak English and has difficulty understanding translator .Self-care deficit R/T [related to] .bathing, bed mobility, dressing, eating, hygiene . and transfers .Bathing - Bath/Shower .alternating days with bed baths. Dependent on Staff .Assist .as needed to desired location .with geri chair [a reclining chair with wheels for people with limited mobility] . Transfers - Assist to desired location with assistance as needed with geri chair as needed .Bed Mobility . Turn/reposition every 2 hours/prn [as needed], assist with bed mobility as needed, monitor skin integrity . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Fall Risk Assessment for Resident #1 dated 12/31/2024, revealed .FALLS HISTORY No falls in past 90 Days .MOBILITY 0 = Bed or chair bound .BALANCE Requires physical assistance .MENTAL STATUS Oriented to person only .TOTAL SCORE: 13 .RISK SCALE 11-19 = Moderate [risk for falls] . Review of Physician Order Sheet for Resident #1 dated January 2025, revealed .Eliquis [a blood thinner medication to prevent blood clotting with the most common side effect of bleeding which can be serious] 5 mg [milligram] tablet: 1 tab [tablet] PO [by mouth] twice daily .aspirin [Nonsteroidal anti-inflammatory drug and also used to prevent blood clotting] 81 mg chewable tablet: 1 tab PO daily .divalproex [anticonvulsant to prevent seizures and other uses] 125 mg capsule, delayed release sprinkle: 2 Tab PO = (250 mg) twice daily .UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE .Zoloft [antidepressant medication] 50 mg tablet .1 tablet PO Q [every]-AM [morning] .DEPRESSION .buspirone [antianxiety medication] 5mg tablet . buspirone 5mg 0.5 tablet PO TID [three times a day] . Antidepressant Monitoring two times a day .Assess Pain two times Daily . Review of the undated facility protocol Treat in Place Protocols / Advanced Nursing Protocols revealed . HEADACHE/JOINT PAIN/GENERALIZED PAIN Symptoms and Interventions: 1. Pain rated at 6 or less (Verbal Pain Scale or FLACC [Face, Legs, Activity, Cry, Consolability] Nonverbal Scale): a. Give 650 mg [milligram] Acetaminophen q [every] 6 hours PRN [as needed] pain for 72 hours; Do not exceed 4 doses in 24 hours. 2. Pain rated at 7-10 .a. Give 650 mg Acetaminophen q [every] 6 hours PRN [as needed] pain for 72 hours; Do not exceed 4 doses in 24 hours. b. Notify MD [Medical Doctor]/NP [Nurse Practitioner] immediately . Review of a facility investigation revealed on 1/25/2025 at 6:30 AM, the Director of Nursing (DON) was notified by the Night Supervisor that Certified Nursing Assistant (CNA) J found Resident #1 with left arm and hip bruising. The Nurse Practitioner (NP) was notified at 7:15 AM and an order was received for immediate x-rays. Staff were interviewed and written statements obtained. CNA V was interviewed at 7:15 AM and stated on 1/21/2025 around 3:30 PM Resident #1 had an unreported fall between the shower bed and Resident #1's bed when CNA V decided to transfer Resident #1 from the shower bed to the Resident's bed unassisted and forgot to lock the bottom wheels of the shower bed. CNA V stated she was maneuvering Resident #1 from the shower bed and the Resident's legs went between the shower bed and Resident's bed causing the Resident's upper body to get stuck between both beds. CNA V stated Resident #1 never fell completely on the floor just her legs went down. The DON documented CNA V was educated by the Director of Nursing (DON) to always double check and make sure both beds are locked before transfer. Review of the undated written statement by the NP revealed, .I was notified on 1/25/25 [2025] in the early AM about pain and bruising on patient's [Resident #1] left side. Order was given to obtain x-rays [Left Shoulder, Left Humerus, Left Elbow, Left Forearm, Left Wrist, Left Hand, Left Hip/Pelvis, Left Femur, Left Knee, Left Tibia and Fibula x-rays] to rule out fracture .call back with result .was notified when results were received .an order was given to send resident to the ER [emergency room] for evaluation . There was no documentation of pain assessments or pain medications being administered to Resident #1 between 1/21/2025 - 1/25/2025. Review of the Radiology (x-ray) Report for Resident #1 dated 1/25/2025 at 3:55 PM, revealed .SHOULDER 1 VIEW, LEFT .Results: There is an acute mildly displaced fracture involving the left humeral neck with adjacent soft tissue swelling .Conclusion: Acute fracture of the left humeral neck . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Nursing Progress Note for Resident #1 dated 1/25/2025 at 4:41 PM, revealed .Report from off going nurse this am [morning] to this writer, resident [Resident #1] was noted to have bruising on LUE [Left Upper Extremity], chest, L [Left] Thigh area and hip. Notified by night supervisor that NP and DON are aware and X-Rays ordered. X-Ray results received and new order noted from [named] NP to send resident out to [named hospital] Hosp ED [Emergency Department] .EMS transported resident at 1641 [4:41 PM]. Called [named hospital] ED, spoke with [Named nurse], gave report on resident coming . Review of the discharge MDS assessment dated [DATE], revealed Resident #1 was .Dependent [staff] does ALL of the effort. Resident does none of the effort to complete the activity .the assistance of 2 or more helpers is required for the resident to complete the activity .for transfers, bed mobility, Shower/bathe self, personal hygiene, dressing, always incontinent bowel and bladder . Review of the facility's Hospital Transfer Form dated 1/25/2025, revealed Resident #1 was sent to Hospital #1 on 1/25/2025 at 4:41 PM for a major injury. The Hospital emergency department (ED) was notified of Resident #1's x-ray results. Review of the hospital Emergency Department (ED) History and Physical for Resident #1 dated 1/25/2025, revealed .transported from a nursing home .the night nurse observed bruising and swelling on her left shoulder and upper arm which was not present before. The cause of these symptoms remains unknown to both the patient and the nursing staff. An X-Ray was performed today revealing a fracture in the left humeral neck [upper arm] .she likely sustained significant trauma, given the humeral fracture .to evaluate for additional injuries . Review of the Hospital X-Ray report dated 1/25/2025, revealed .impression .acute moderately displaced fracture . Review of the Hospital X-Ray report dated 1/28/2025, revealed .There is acute fracture of the distal [right] femur [just above the knee] with bony impaction [the ends of the broken bone have been driven forcefully into each other] . Review of the hospital Physician note dated 2/3/2025, revealed .Per [according to] ED report, concern current [nursing home] facility unsafe for patient . 3. Review of the written statement by Licensed Practical Nurse (LPN) C dated 1/25/2025, revealed .at the beginning of the shift I was instructed by unit manager from night shift to call DON about bruising that was noted on night shift . [Named Resident #1]. I spoke with DON and then gave my cell phone to check [Named CNA V] to speak with her about patient [Resident #1]. X-ray results came back with injury. I then was instructed to send patient [Resident #1] to hospital . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the written statement by CNA J dated 1/25/2025, revealed .incident report on . [named Resident #1], When I came in on my shift on Friday, the resident was already in bed, nobody tell [told] me anything about the resident. So I did my care on her around 9 PM [9:00 PM] but she was moaning which is not new to me but I asked her if she is okay, that's when her roommate said that since she took a shower she has been like that, I said okay because sometimes she does that. So I continue my care for the rest of the shift but when in my AM- care she still persisted, I decided to take her [Resident #1] gown off to check on her thoroughly that's when I discovered the resident left arm swelling and covered with old purple bruises so I notify the nurse immediately [to see] if they are aware of it [left arm swelling and bruises]. The resident did not fall my shift, none [neither] did any incident occurred on my shift Review of the undated written statement by CNA V revealed, .On 1/21/25 [Named Resident #1] received her shower around 3:30 PM. The battery was down on the lift [mechanical lift], so I decided to transfer her [Resident #1] by sliding her on the lift pad from the shower bed to her bed. I made sure the bed was locked. I locked the shower been [bed] at the top and middle I forgot to lock the bottom wheel on the shower bed. When I proceeded to pull her [Resident #1] from the shower bed her legs went between the bed and shower bed causing her upper body to be stuck between both beds. I was able to grab her legs and rolled her on to her bed. When the shower bed shifted her left arm that she doesn't use was raised at a higher level than normal. She never fell completely on the floor just her legs went down . 4. During a telephone interview on 2/3/2025 at 11:30 AM, the Adult Protective Services (APS) worker stated she received a report from the hospital social services about Resident #1 who had a broken arm. The APS worker stated the investigation was in progress. Review of an email received on Monday, 2/3/2025 at 12:01 PM, to the surveyor from the APS worker revealed, .The client [Resident #1] is still admitted to [Named Hospital]. The client has an expected discharge date of ,d+[DATE] [2025]. However, it is unclear at this time where she [Resident #1] will discharge to. The client also has a history of intellectual disability noted with intellectual disorder and neurocognitive disorder charted for this admission. The client is also verbal but speaks in short sentences. Additionally, the client was also found to have a right femur fracture in addition to the acute bruising and swelling to the right humerus that was reported . 5. During an interview on 2/5/2025 at 9:41 AM, the Assistant Director of Nursing (ADON) stated that accidents, falls and incidents should be reported immediately to the Charge Nurse, during the investigation the Event Note is completed, the provider is notified, the responsible party, and the ADON or DON is notified whichever is appropriate. The ADON stated Resident #1 would respond to being asked if in pain by nodding her head. The ADON stated, I would ask her in English are you in pain, make a frown, point to my head, and she would nod yes or no. I was not on the floor from 1/21/2025 through 1/25/2025. I didn't take care of [named Resident #1] that much. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/5/2025 at 9:44 AM, CNA V was asked about the incident on 1/21/2025 with Resident #1. CNA V verified her written statement in the facility investigation. CNA V stated, It [Resident #1's fall] happened on 1/21/2025 around 3:00 to 3:30 PM . had given [Named Resident #1] a bath. I went to get the [named mechanical lift] lift, the lift was on the hall, when I got the lift, the battery was dead, and the lift was not working. I took her [Resident #1] to her room on the shower bed. [Named Resident #1] is a 2-person assist. I was the only one on the hall at the time. I couldn't leave her [Resident #1] by herself on the shower bed. There was no one to assist. I was sliding her [Resident #1] from the shower bed to her bed. She [Resident #1] was already on the lift pad on the shower bed. I was sliding her from the shower bed to her bed using the lift pad that was under her. I made sure her bed was locked and positioned at proper height a little lower than [the] shower bed. It was approximately 2 inches lower than the shower bed. The shower bed was pushed against the side of her bed with no cracks between the beds, pushed all the way over touching the sides of the beds together. The resident [Resident #1] was lying flat on her back on the lift pad. The lift pad was thick, it covered her from her head to the calves of her legs. I went around and locked the top part of the shower bed, the middle part of the shower bed, and I forgot to lock the bottom part of the shower bed. I went to the opposite [right side] of the Resident's bed then I grabbed the lift pad to pull her [Resident #1] into her bed. I had done this before with another resident and another staff member present helping. When I pulled her the weight of her legs separated the bottom of the shower bed from the resident's bed. Her [Resident #1] legs touched the floor, her upper body was on shower bed and the resident's bed supported by her arms. Her right arm was on the Resident's bed and her left arm was on the shower bed. I had to squat down and get under the middle part of her back, under her bottom, and legs. I got her [Resident #1] up in the bed. I rolled her on her right arm then straightened her positioning. I didn't call for help or ring the call light because I thought she was okay because she did not hit the floor. CNA V was asked if she heard snapping or cracking noises. CNA V stated, No, the resident [Resident #1] screamed out because it scared her. When I dried her off with a towel, she let out a squeal, and she does that when she doesn't want to be bothered. The rest of the shift the resident [Resident #1] did not behave out of the normal. I worked the next day, on my off day, and worked another section. [Named Resident #1] has a tendency to throw up and make noise when she doesn't want to be bothered. CNA V was asked what the facility's policy was when there was an accident or fall with a resident. CNA V stated, To report it to your charge nurse when it happens. CNA V was asked what the policy for two-person transfer was. CNA V stated, To always have a second person with you to transfer the resident. The reason I didn't get help is the person at the top of the hall was at lunch or break and not on the hall. I could get a nurse; I didn't want to leave the resident [Resident #1] on the shower bed alone. CNA V was asked when in a resident's room, and you need another person to assist you and cannot leave the resident alone then how would you get help. CNA V stated, You can cut [turn] on the call light. I wish that I had not been moving so fast and didn't get help. I hate that it happened to the resident [Resident #1]. I learned that next time don't try to do things on my own, get help. CNA V was asked when she reported the incident to the facility. CNA V stated, When the DON talked to me on 1/25/2025 I told her what happened . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/5/2025 at 5:20 PM, CNA J was asked about the incident involving Resident #1. CNA J verified her statement in the facility investigation. CNA J was asked about the incident with Resident #1 and if she had worked with Resident #1 between 1/21/2025 and 1/25/2025. CNA J stated she had worked on Tuesday 1/21/2025 with Resident #1 for about an hour from 7:00 PM to 8:00 PM then was asked to swap assignments with another CNA. CNA J stated Resident #1 was throwing up a small amount. CNA J never had to remove all of Resident #1's clothing. CNA J stated on that Friday (1/24/2025) Resident #1 hollered when she saw CNA J. CNA J stated around 9:00 PM when changing Resident #1, Resident #1 was moaning. CNA J stated she had asked Resident #1 if she was ok and Resident #1's roommate stated, Since she took a shower, she has been like that. CNA J stated she used a draw sheet to turn Resident #1 and Resident #1 moaned. CNA J stated at 12:00 AM rounds she noticed Resident #1 had been moaning since the beginning of her shift and she overlooked it because she would do that sometimes after getting a shower. CNA J stated at the 4:00 AM rounds when she went to check on Resident #1, she was still moaning. CNA J stated, she felt like something was not right with Resident #1 due her moaning even when care was not being given. CNA J stated, I removed her [Resident #1] clothing to do a skin check to see if something was hurting her. She [Resident #1] was wearing a large gown that covered her chest and arms. When I removed her [Resident #1's] gown I saw her upper left arm was swollen with a dark purple bruise, her chest had a purple and green colored bruise, and I went and told the nurse who was an agency nurse. [Named Agency LPN] came to the room and did a full body skin check, bruises were found on her left arm, left elbow, chest, left hip, and dark bruises were found on both her ankles. During a telephone interview on 2/5/2025 at 7:00 PM, Family Member H was asked about Resident #1's incident and hospitalization . Family Member H stated The facility broken [broke] my sister's arm and leg. How did it happen? Family Member H was speaking in broken English sentences and asked Family Member H what was his primary language and if he wanted an interpreter for the phone interview. Family Member H declined an interpreter. Family Member H stated his primary language was Arabic, and he speaks and understands English. Family Member H was asked if he was notified Resident #1 was sent to the hospital. Family Member #1 stated, Just one call. The facility said your sister was sent to the Hospital due to a broken arm. No reason was given. Family Member H was asked if he had asked Resident #1 what happened. Family Member #1 stated, She [Resident #1] said they pushed me in the floor. She did not say how. When I meet her in the hospital, she [Resident #1] said she was afraid to go back to facility. She is afraid to complain .My sister [Resident #1] gets nausea, and the hospital found a stomach infection and her right leg bone above the knee is broken . Family Member H was asked if Resident #1 will return to the facility after hospital discharge. Family Member H stated, She [Resident#1] is still in the hospital, will not return to facility she is afraid . During an interview on 2/6/2025 at 8:40 AM, the Administrator was asked about the incident involving Resident #1. The Administrator stated, I was briefed by the DON of the incident. [Named Resident #1] fell , and it was not noted . The Administrator confirmed Resident #1 had a fall while a CNA was transferring Resident #1 by themself, and Resident #1 suffered a broken arm. The Administrator stated, I don't think it was malicious I think the CNA just made a mistake. Everyone makes mistakes. The Administrator stated, .we didn't know about the incident, the CNA should have reported it immediately .the CNA neglected to lock the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/2025 at 1:45 PM, the NP was asked about the incident involving Resident #1. The NP confirmed her written statement in the facility investigation. The NP stated, The facility called me early in the morning on Saturday 1/25/2025 about [Named Resident #1] had bruises on her left side, shoulder and leg. I ordered stat x-rays .When I received the x-ray results, it showed Resident #1 had an acute fracture of the left arm . The NP was asked if any pain medication was ordered due Resident #1's incident. The NP stated, No, staff did not report resident had any signs or symptoms of pain. During an interview on 2/6/2025 at 4:26 PM, the DON was asked about the incident involving Resident #1. The DON stated, On 1/25/2025 I received a call from the night shift Unit Manager RN [registered nurse] and she stated that bruising was noted on [Named Resident #1] Left arm, left hip, and chest. The night shift CNA [CNA J] found the bruises .The CNA [CNA J] and nurse denied any falls or incidents on their shift. I asked the nurse to ask the staff if any incident happened. When I asked [named LPN C] if any reports of any incidents with [Named Resident #1] she said none she was aware of. I asked [named LPN C] to find [named CNA V] and when I asked [CNA V] she admitted to the incident .that she gave her [Resident #1] a shower on 1/21/2025, put the beds together and she didn't lock the bottom lock on the shower bed and the resident fell between both beds . The DON confirmed accidents and falls should be reported immediately, CNA V should have asked for assistance with transferring Resident #1 and Resident #1 was sent to the hospital for a left arm fracture.