

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2026
NAME OF PROVIDER OR SUPPLIER  Century Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  301 Centinela Ave Inglewood, CA 90302	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure licensed nursing staff informed four out of four sampled residents (Residents 11, 22, 23, and 51) of the medications prior to medication administration. These deficient practices violated Residents 11, 22, 23, and 51's right to participate during medication administration. Findings During a review of Resident 11's admission Record, the admission record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 11's History &amp; Physical (H&amp;P), dated 2/22/2025, the H&amp;P indicated Resident 11 had fluctuating capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 11 was usually able to understand and be understood by others. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene, toileting hygiene, showering/bathing, lower body dressing, and personal hygiene. During an observation on 4/9/2026 at 10:09 a.m. in Resident 11's room, Licensed Vocational Nurse (LVN) 1 was observed giving Resident 11 medication cups without explaining what medications were being administered. Resident 11 then swallowed the pills. During a review of Resident 22's admission Record, the admission record indicated Resident 22 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 22's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), schizophrenia (a mental illness that is characterized by disturbances in thoughts), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 was usually able to understand and be understood by others. The MDS indicated Resident 22 was dependent (helper does all the effort) on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 22's H&amp;P dated 12/22/2025, the H&amp;P indicated Resident 22 did not have the capacity to understand and make decisions. During an observation on 4/9/2026 at 9:48 a.m. in Resident 22's room, LVN 1 was observed giving Resident 22 medication cups without explaining what medications were being administered. Resident 22 then swallowed the pills. During a review of Resident 23's admission Record, the admission record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included hypertension, schizophrenia, and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 23's H&amp;P dated 12/15/2025, the H&amp;P indicated Resident 23 had the capacity to understand and make decisions. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 was able to understand and be understood by others. The MDS indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 4/9/2026 at 8:58 a.m. in (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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 23's room, LVN 3 was observed giving Resident 23 medication cups without explaining what medications were being administered. Resident 23 then swallowed the pills. During a review of Resident 51's admission Record, the admission record indicated Resident 51 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 51's diagnoses included COPD, paranoid schizophrenia, and anxiety. During a review of Resident 51's H&amp;P dated 11/17/2025, the H&amp;P indicated Resident 51 had fluctuating capacity to understand and make decisions. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 was usually able to understand and be understood by others. The MDS indicated Resident 51 required partial/moderate assistance from staff for toileting hygiene, shower/bathe self, lower body, and putting on/taking off footwear. During an observation on 4/9/2026 at 9:58 a.m. in Resident 51's room, LVN 1 was observed giving Resident 51 medication cups without explaining what medications were being administered. Resident 51 then swallowed the pills. During an interview on 4/9/2026 at 11:30 a.m. with LVN 1, LVN 1 stated if the residents ask what medication you are giving them you should tell them. LVN 1 stated residents need to know what medication they are receiving in case they want to refuse. During a review of P&amp;P titled Resident Rights dated January 2026, the P&amp;P indicated the facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. During a review of P&amp;P titled Medication Administration dated January 2026, the P&amp;P indicated the administering nurse should explain the purpose of the visit.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to complete discharge documents for one of one sampled resident (Resident 84) prior to discharge on [DATE]. This failure has the potential for Resident 84 to not know the appeal process and for the receiving facility to have inaccurate information of Resident 84. Findings During a review of Resident 84's admission record, the admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses including unspecified complicated cataract (a medical condition that causes blurred vision), hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD, a progressive, long-term lung disease that makes it hard to breathe). During a review of Resident 84's History &amp; Physical (H&amp;P), dated 7/10/2025, the H&amp;P indicated Resident 84 had fluctuating capacity to understand and make decisions. During a review of Resident 84's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 84 was discharged to the home/community and would not return to the facility. The MDS indicated an active discharge plan was in process for a return to the community. During a review of Resident 84's physician order, dated 3/19/2026, the physician order indicated Resident 84 may discharge to an assisted living facility for lower-level care. During a review of Resident 84's progress notes, dated 3/19/2026, the progress notes indicated Resident 84 was alert, oriented, and stable for transfer to a lower level of care. The progress notes indicated Resident 84 was discharged on 3/19/2026 at 10:20 a.m. in stable condition with all current medications, personal belongings, and necessary documents. During a concurrent interview and record review on 4/9/2026 at 1:00 p.m. with the Social Services Director (SSD), Resident 84's medical records were reviewed. There was no Notice of Proposed Transfer nor discharge summary in the medical records. The SSD stated the nurses fill out the Notice of Proposed Transfer and oversee faxing the notice to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities). The SSD stated it was important to let the resident know the discharge information because the Notice also included information regarding an appeal process. The SSD stated it was important to let the ombudsman know that the resident would be transferred to another facility. During a concurrent interview and record review on 4/9/2026 at 1:30 p.m. with the Director of Nursing (DON), Resident 84's medical records were reviewed. The DON stated there was no discharge summary. DON stated it was very important to document the discharge summary. During a review of the facility's policy and procedure (P&amp;P) titled, Transfer and Discharge (Including AMA), dated 01/2026, the P&amp;P indicated for non-emergency discharges (initiated by the facility, return not anticipated), the Social Services Director would notify the resident and resident's representative in writing at least 30 days before the resident is transferred or discharged. The P&amp;P indicated the contents of the notice must include the reason for transfer or discharge, effective date of transfer or discharge, the location to which the resident is transferred or discharged, and a statement of the resident's appeal rights. The P&amp;P indicated for a community discharge, a discharge summary and plan of care should be prepared for the resident.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 9) had care plans (a personalized document outlining a resident's health needs, goals, and specific interventions) for diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). This deficient practice had the potential to result in delayed care and services for Resident 9's mental health. Findings During a review of Resident 9's admission Record, the admission record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included unspecified dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 9's History and Physical (H&amp;P) dated 10/9/2025, the H&amp;P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 1/13/2026, the MDS indicated Resident 9 was usually understood and could usually understand others. The MDS indicated Resident 9's cognition (ability to think and understand) was moderately impaired. The MDS indicated Resident 86 was independent with eating and oral hygiene. During a concurrent interview and record review on 4/9/2026 at 11:35 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 9's Care Plans were reviewed. The care plans indicated there were no care plans for schizophrenia or depression. LVN 1 stated there should be a care plan for diagnoses schizophrenia, and depression so staff would know the interventions (actions to take to improve a situation) in case Resident 9 showed behavioral issues. During an interview on 4/10/2026 at 9:20 a.m. with the MDS Nurse, MDS Nurse stated the initiation of care plans was a team effort and should be checked during quarterly updates of the MDS by the MDS Nurse. The MDS Nurse stated the purpose of the care plan was to ensure Resident 9's goals and interventions are being met. During a review of the facility's Policy and Procedure (P&amp;P) titled Comprehensive Care Plans dated 1/2026, the P&amp;P indicated the comprehensive care plan would describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&amp;P indicated the comprehensive care plan would include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure physician orders for lab work, medical procedures, chest x-ray and dental referral were carried out for one of four sampled residents (Resident 26). This deficient practice had the potential to result in delayed diagnosis, delayed treatment, and/or worsening of Resident 26's condition. Findings During a review of Resident 26's admission Record, the admission Record indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbance in thought) and suicidal ideations (thinking about wanting to die or considering suicide) During a review of Resident 26's Minimum Data Set (MDS- a resident assessment tool), dated 1/29/2026, the MDS indicated Resident 26's cognition (process of thinking) was intact and unimpaired. The MDS indicated Resident 26 was independent with activities of daily living eating (bathing, toileting, and eating), required set-up assistance from one staff member for toileting and required supervision from staff for bathing and lower body dressing. Resident 26 was able to walk about the facility independently without the use of a walker or wheelchair. During a review of Resident 26's History and Physical (H&amp;P), dated 3/3/2026, the H&amp;P indicated Resident 26 had the capacity to understand and make decisions. During a review of Resident 26's Ear Nose and Throat Consultation note (ENT note), dated 3/26/2026, the ENT note indicated Resident 26 was diagnosed with a right jaw lymph node and to refer to dentist (referral to dentist for further evaluation). During an interview on 4/8/2026 at 11:48 a.m. with the Social Service Director (SSD), the SSD stated they missed the order to refer Resident 26 to the dentist. The SSD stated she was not aware of the referral request and placed the ENT note in the logbook without alerting the dentist about the order for the dental referral. During a review of Resident 26's physician progress notes dated 4/3/2026, the physician progress notes indicated Resident 26 wanted to be tested for pancreatic, colon cancer and other types of cancer because he claimed his sister was dying of cancer. The PPN indicated a request for Resident 26 to have a stool for occult blood (a test to detect blood in the stool), a chest x-ray (a photo imaging exam of the lungs, heart, airways and ribs used to detect abnormalities), an abdominal ultrasound (a scan that shows organs in the belly, the liver, gallbladder, kidneys, pancreas and blood vessels used to detect abnormalities), and a colonoscopy (a procedure where a camera scope is used to look inside the colon and rectum to detect abnormalities). During a concurrent interview and record review on 4/8/2026 at 11:48 a.m., with the Director of Staff Development (DSD), the DSD stated orders for the stool for occult blood, chest x-ray, abdominal ultrasound, and colonoscopy were not carried over into Resident 26's physician orders and therefore missed and not transcribed. The DSD stated Resident 26 did not receive the lab work or testing that the physician ordered on 4/3/2026. The DSD stated the delay could potentially delay care and services for Resident 26. During review of the facility's Policy and Procedure (P&amp;P) titled Medication Orders, dated 1/2026, the P&amp;P indicated for handwritten orders signed by the physician, the charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure the arbitration agreement accurately reflected the residents' right to rescind the agreement within 30 days for three out of three sampled residents (Residents 15, 26, and 41). This deficient practice had the potential to misinform residents of their rights and limit their ability to voluntarily withdraw from the arbitration agreement. Findings. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included schizoaffective disorder bipolar type (a mental illness that is characterized by disturbance in thought), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 15's History and Physical (H&amp;P) dated 12/8/2025, the H&amp;P indicated Resident 15 had fluctuating capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 3/20/2026, the MDS indicated Resident 15's cognition (process of thinking) was intact and unimpaired. The MDS indicated Resident 15 was independent in functional abilities including eating toileting dressing and personal hygiene. The MDS indicated Resident 15 independently without the use of a wheelchair, walker or cane. b. During a review of Resident 26's admission Record, the admission Record indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia and suicidal ideations (thinking about wanting to die or considering suicide) During a review of Resident 26's MDS, dated [DATE], the MDS indicated Resident 26's cognition was intact and unimpaired. The MDS indicated Resident 26 was independent with activities of daily living eating (bathing, toileting, and eating), required set-up assistance from one staff member for toileting and required supervision from staff for bathing and lower body dressing. Resident 26 was able to walk about the facility independently without the use of a walker or wheelchair. During a review of Resident 26's H&amp;P, dated 3/3/2026, the H&amp;P indicated Resident 26 had the capacity to understand and make decisions. c. During a review of Resident 41's admission Record, the admission Record indicated Resident 41 admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety disorder (being worried nervous or scared most of the time) and depression (feeling sad and low for long periods of time). During a review of Resident 41's H&amp;P dated 7/31/2025 the H&amp;P indicated Resident 41 had fluctuating capacity to understand and make decisions. During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41's cognition was intact and unimpaired. The MDS indicated Resident 41 was independent in functional abilities including eating toileting dressing and personal hygiene. The MDS indicated Resident 41 walked about independently without the use of a wheelchair, walker or cane. During a review of the facility's Arbitration Agreement title, Resident -Facility Arbitration Agreement undated, the Arbitration Agreement indicated, This agreement may not be rescinded by written notice within thirty (30) days of signature. During a concurrent interview and record review on 4/9/2026 at 3:43 p.m., with the Social Services Director (SSD), the SSD indicated the Facility Arbitration Agreement had a typographical error indicating residents may not rescind the agreement, the SSD indicated that was the agreement residents were signing the last 3 years. The SSD indicated the agreements containing the typographical were signed by Resident 15 on 6/6/2025, Resident 26 on 1/19/2026, and Resident 41 on 7/31/2024. During an interview on 4/10/2026 at 10:10 a.m., with the Administrator (ADM), the ADM indicated having the typographical error in the Resident -Facility Arbitration Agreement had the potential to violate resident rights by not providing the residents with the 30-day time period to rescind the agreement. During a review of the facility's policy and procedure (continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(P&amp;P) titled, Binding Arbitration Agreements, dated 1/2026, the P&amp;P indicated, It is the policy of this facility not to enter into a pre- dispute agreement for binding arbitration with any resident or resident representative nor require that a resident sign an arbitration agreement as a conditions of admission to the facility.</p>		