DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185388		11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF LOUISVILLE	240 MASONIC HOME DRIVE MASONIC HOME, KY 40041

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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 11/03/15 and concluded on 11/05/15 with deficiencies cited at the highest scope and severity of a "D".	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1. The following corrective actions have been taken to address the identified issues in items 3.4.and 5: • The Director of Nursing and SDC re-inserviced CNA #1 on facility infection control policy, isolation precautions and use of PPE related to precautions completed 11/3/15. • The Director of Nursing and SDC re-inserviced CNA #2 on facility infection control policy, isolation precautions and use of PPE related to precautions completed 11/3/15. • The Marsh Nurse Leader educated Family member in room of resident #19 on resident's infection process, the reason for the isolation precautions and use of PPE equipment when entering and exiting the room on 11/6/15 2. Other residents were not determined to have the potential to be affected by the identified issues. The facility has implemented corrective actions to address identified issues items 3 4, d 5. • The Director of Nursing and Nursing House leaders conducted a 100% audit of all residents and rooms under isolation precautions and re-educated families completed 11/20/15. • The Director of Nursing and SDC conducted re-inservicing to direct care staff on isolation precautions and use of PPE equipment completed 11/30/15. • The Director of Nursing/Nurse Leaders of Marsh and Walters conducted education to families of residents under isolation precautions on the specific infection, precautions and appropriate PPE use completed on 11/20/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] | TITLE: X Administrator X | (X6) DATE: 12/2/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 441	Continued From page 1 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain effective infection control practices for two (2) of twenty-four (24) sampled residents, (Residents #15 and #19). Certified Nursing Assistants (CNA's) #1 and #2 were observed entering a Contact Precautions room lifting bed linen, kneeling on the floor, opening and closing drawers, moving the resident's personal belongings around, and handling items on the resident's bedside table. The CNA #1 failed to apply Personal Protective Equipment (PPE) and CNA #2 applied gloves only. A family member was observed in a Contact Precautions room without PPE on who stated the facility failed to educate him/her of the safety precautions regarding a contact precaution room. The findings include: Review of the facility's policy regarding Contact Precautions, not dated, revealed the staff used contact precautions for residents known to have serious illnesses that were transmitted by direct resident contact or by contact with items in the resident's environment. Contact precaution were used by the facility for residents who had	F 441	3. The facility has initiated the following corrective measures to ensure the identified issues do not reoccur: • The Director of Nursing and Infection Control Committee revised the process for resident responsible party (RP) education and implemented the " Transmission Based Precaution Education" document to be signed by the resident RP indicating they have been informed of the facility infection control and isolation protocols completed 11/20/15. • The Director of Nursing revised the "Isolation Process" documented in the electronic medical record to include family education when placing a resident in isolation initiated 11/20/15 • The Director of Nursing and Staff Development Coordinator conducted re- inservicing of nurses, cnas, cmts, housekeepers, homemakers and maintenance staff of infection control policy including isolation precautions and PPE use completed 11/30/15. • The Director of Nursing/SDC educated all licensed staff on the Transmission Based Precautions Education and Isolation Process completed 11/30/15 4. The facility has implemented the following interventions to monitor corrective actions to ensure performance is sustained: • The Director of Nursing, ADON, Nurse Leaders, and Shift Supervisors will complete daily audits on all shifts to assess compliance on the following schedule; on all shifts daily X 2 weeks; daily for one week,2 X per week for 4 weeks and then monthly X 3 months. The DON will present audit results to QA Committee monthly, the committee will make any further recommendations. Initiated 11/23/15 • The Director of Nursing and Clinical at Risk Committeee will audit completion of resident family education on all isolation residents each week in clinical at risk meeting. Initiated 11/25/15 5. The Quality Assurance Committee (QA) will review the required audits presented by the Director of Nursing to ensure effectiveness of compliance and make revisions as necessary on an ongoing basis implemented	12/1/15

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F 441	Continued From page 2 acquired Methicillin-Resistant Staphylococcus Aureus (MRSA), a multi-drug resistant organism, to prevent the spread of the bacteria. Review of the Centers for Disease Control (CDC) Guideline regarding Precautions to Prevent the Spread of MRSA in Healthcare Settings, not dated, revealed Contact Precautions required gloves and gowns to be worn upon entry into a room of a patient/resident who was known to have MRSA. Review of the facility's Community Immunity pamphlet, not dated, described the different types of hospital acquired infections and how to avoid them. This pamphlet was given to each family/resident as part of the admission process, but it did not provide individualized education regarding infection or recommended PPE for a specific resident and family. 1. Review of Resident #15's clinical record revealed the facility admitted the resident on 09/23/15 with diagnoses of a Fractured Lower End of the Right Femur, Closed Fracture with Routine Healing, Acquired Absence of the Right Leg Above the Knee (RAKA). Review of Resident #15's Discharge Summary, dated 10/31/15, revealed on 10/23/15, Resident #15 was transferred to the hospital's Emergency Room Department due to pus coming from an open wound on the resident's RAKA which contained Vancomycin-resistant Enterococcus (VRE) growth and cellulitis and admitted. On 10/31/15, Resident #15 was discharged from the	F 441		

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F 441	Continued From page 3 hospital and re-admitted to the nursing facility with a Wound VAC (Vacuum Assisted Closure) applied to the RAKA site. Review of Resident #15's Physician Order Sheet, dated November 2015, revealed the staff was to place the resident in contact isolation on 10/31/15. Review of Resident #15's Care Plan, dated 10/09/15, revealed nursing staff were to follow contact isolation precautions to prevent cross-contamination to visitors and employees. Review of Resident #15's Resident Summary (CNA Assignment Sheet), dated 10/31/15, revealed the CNAs were to follow contact isolation precautions for Resident #15 related to the right leg surgical wound with a Wound VAC. Observation, on 11/03/15 at 3:17 PM, revealed two (2) CNA's entered Resident #15,s room then proceeded to lift bed linen and pillows on the bed, kneeled on the floor looking under the bed and a chair, touched the resident's personal belongings and clothes, opened and closed drawers, touched items on the resident's bedside table, and walked in and out of the resident's bathroom. CNA #2, who entered the room first, had gloves on, and CNA #1 was not wearing any PPE. Interview with CNA #1, on 11/03/15 at 3:34 PM, revealed she had entered into Resident #15's room to look for the resident's cell phone and she had touched items in Resident #15's room	F 441		

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F 441	Continued From page 4 attempting to locate the cell phone. CNA #1 stated she knew the resident was in isolation because of the cart that was outside the room, but since she didn't touch Resident #15, she wasn't required to wear PPE. CNA #1 also stated she had been trained by the facility's Staffing Coordinator to put on PPE before entering a resident's room who was in isolation to prevent the spread of infection to other residents and staff. Interview with CNA #2, on 11/03/15 at 4:05 PM, revealed she didn't put a gown on before she entered Resident#15's room because there wasn't any in the drawer and she would just quickly look for the resident's cell phone and leave the room. CNA #2 stated she thought it would be all right not to put the gown on because she had not given the resident personal care. CNA #2 also stated she was trained on Contact Precaution when she was employed in an assisted living facility. CNA #2 stated the purpose of PPE was to protect staff and residents from getting germs. Interview with the Unit Manager, on 11/04/15 at 11:56 AM, revealed staff was required to put PPE on before entering into an isolation room to prevent the spread of infection. The Unit Manager stated all staff had received orientation and in-services on infection precautions and protocols by the Staffing Coordinator and via computer. The Unit Manager also stated PPE gowns were located in the clean utility room on the unit and there was no excuse for staff not to put it on before entering a contact precaution room.	F 441		

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F 441	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #4, on 11/04/15 at 4:28 PM, revealed she had often provided care to Resident #15 and she knew that Resident #15 had VRE that was located in the resident's wound according to the infectious disease doctor. LPN #4 stated Resident #15 was placed in isolation and all staff was required to wear PPE before going into the resident's room to prevent transferring the infection to other residents because it would cause more residents to become ill. 2. Review of Resident #19's Clinical Record revealed the facility admitted the resident on 10/13/15 with diagnoses of Sepsis related to Methicillin-resistant Staphylococcus aureus (MRSA) and Infection of Post-Operative Vascular Graft. Review of Resident #19's Physician Order Sheet, dated 11/05/15, revealed Resident #1 had an order that placed the resident in contact isolation on 10/13/15. Review of Resident #19's Care Plan, dated 10/21/15, revealed nursing staff were to follow contact isolation precautions for Resident #19 to prevent cross-contamination to visitors and employees. Observation, on 11/04/15 at 4:15 PM, revealed a stop sign outside Resident #19's door, instructing individuals to see the Nurse before entering and a PPE cart was to the right of the door. A gentleman was in Resident #19's room without	F 441		

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F 441	Continued From page 6 any PPE on his person at the time. Interview with LPN #8, on 11/04/15 at 4:20 PM, revealed he had not educated Resident #19's family about the use of PPE and he was not sure if anyone else had either. Interview with LPN #3, on 11/05/15 at 9:15 AM, revealed the nursing staff educated the family and residents regarding the disease process related to infection and PPE. They do not demonstrate application of PPE, unless the family has requested it. She was not sure if Resident #19's family had been educated and she stated the education was not documented. She also stated when the wound was contained staff had difficulty getting the family to don PPE. Interview with Resident #19's family member, on 11/05/15 at 10:30 AM, revealed he/she was in Resident #19's room on 11/04/15 without PPE. He/she stated they had not received any education about MRSA or PPE from the facility. He/She did not think it was necessary. Interview with LPN #6, on 11/05/15 at 11:15 AM, revealed she was an agency staff and had worked for the facility for (two) 2 days. She stated the report sheet showed Resident #19 had MRSA and PPE was ordered. She stated she had infection control training within the last few months. Interview with LPN #7, on 11/05/15 at 11:20 AM,	F 441		

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F 441	Continued From page 7 revealed he had worked for the facility for one and one half (1½) years and had been Resident #19's primary nurse on day shift. He stated Resident #19 had been on precautions since his/her admission. He stated he was trained on infection control with an online module and didactic methods. He did not educate the family regarding PPE or infection control stating he thought it was done on admission. Interview with Nurse Leader #1, on 11/05/15 at 11:30 AM, revealed the stop signs on the door had specific directions on the back describing the type of precautions and what PPE the staff was specifically to use. This helped CNAs to remain knowledgeable about the appropriate PPE. Families were educated on admission or if an infection developed following admission, but it was not documented. All families were given a Community Immunity pamphlet, as well. Interview with the Director of Nursing (DON), on 11/05/15 at 1:32 PM, revealed it was facility's policy for staff to put on PPE before entering into a contact precaution room for the protection of staff and other residents in the facility. The DON stated after the physician orders the resident to be placed in isolation the nursing staff put a cart containing PPE outside the resident's door and place a sign on the wall outside the residents room, the signed informs staff what type of PPE is required to be worn before they enter the contact precaution room. The DON also stated nursing staff was trained by the Staff Development Coordinator annually and they were in-serviced throughout the year on the on-line computer system. The DON stated she expected	F 441		

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F 441	Continued From page 8 all staff to wear PPE as stated on the back of the sign outside the contact precaution rooms, before they entered the room. The DON further stated leadership staff had a track and trend system in place on infection control and they discussed the findings in their monthly meetings. Interview with the Administrator, on 11/05/15 at 1:32 PM, revealed staff was to put on PPE before entering an isolation room to protect residents, staff, and family members from acquiring the infection of the resident. The Administrator stated staff was trained during the orientation process of newly hired employees, staff had been in-serviced annually, staff were updated during the flu season and they had received additional training as needed on infection control and PPE. The Administrator stated the Nurse Managers and the Infection Control Nurse monitored staff and the residents that have been placed in isolation to ensure proper isolation protocols were in place and were adhered to by the staff, residents, and visitors. The Administrator also stated staff should not have entered an isolation room without PPE.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 456	1. Residents who were assigned accuchecks on Walters and Chandler Houses were addressed as follows: • The Director of Nursing and the Nursing House Leaders assigned to Walters and Chandler Houses audited all residents with orders for accuchecks, notified the attending MD of the lack of daily quality checks (QC) on glucometers , obtained orders to draw AIC levels and reported results to attending MD or nurse practitioner completed 11/6/15. There were no AIC results found to be abnormal for any resident. • The Director of Nursing conducted a check of all glucometers on Houses to ensure that the QC feature was properly set to auto check function completed	

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F 456	Continued From page 9 the facility's policy, it was determined the facility failed to ensure glucometers were in safe operating condition by performing daily quality control tests on four (4) of twelve (12) glucometers on Walters House and Chandler House. The findings include: Review of the facility's policy regarding Blood Glucose Monitoring, revised June 2015, revealed quality control procedures were to be performed daily. Review of the Nightly Duties for nurses, not dated, revealed glucometer logs were to be completed nightly. Review of the Blood Glucose Monitoring System Daily Quality Control logs for Walters House, dated October 2015, revealed glucometer number one (#1) had only been tested twenty-two (22) out of thirty-one (31) days. Glucometer number two (#2) had only been tested twenty (20) out of thirty-one (31) days. Glucometers number one (#1) and number two (#2) had only been tested one (1) of three (3) days for the month of November 2015. Review of the Blood Glucose Monitoring System Daily Quality Control logs for Chandler House, dated October 2015, revealed glucometer number one (#1) and number two (#2) had only been tested twenty (20) out of thirty-one (31) days. Glucometers number one (#1) and number two (#2) had only been tested one (1) of three (3) days for the month of November 2015. Interview with Licensed Practical Nurse (LPN) #4,	F 456	11/4/15 • The Director of Nursing and Staff Development Coordinator educated licensed staff on the revised glucometer logs for Houses completed 11/16/15. 2. All other resident who were assigned accuchecks on the other Houses were addressed as follows: • The Director of Nursing and Nursing House leaders assigned audited all residents with orders for accuchecks, notified attending MD of possible lack of glucometer QC , obtained orders to draw AIC levels and reported results to attending MD/ nurse practitioner completed 11/6/15. There were no AIC levels found to be abnormal for any resident. • The Director of Nursing and Nursing Leaders are conducting daily audits of glucometer QC test logs for compliance initiated 11/16/15. •The Director of Nursing/ADON conducted a check of all glucometers on Houses to ensure that QC feature was properly set to auto check function completed 11/4/15 3. The facility initiated the following corrective measures to ensure the identified practice does not reoccur: • The Director of Nursing revised the Glucometer QC Log to remove unnecessary data initiated on 11/16/15 • The Director of Nursing/SDC educated all nurses on the glucometer testing process and the Glucometer testing log completed 11/30/15 • The Director of Nursing revised the RN/LPN new hire orientation checklist to include revised glucometer daily QC monitoring log on 11/25/15 4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained: • The revised Glucometer QC log will be audited daily by DON and Nurse Leaders for compliance for one month on each Household, then three times a week for 4weeks, twice a week x4 weeks, weekly x4weeks, twice a month x3months and presented findings to QA Committee for further recommendations started 11/16/15 • The Director of Nursing will report compliance audit to the QA Committee monthly initiated 11/30/15	

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F 456	Continued From page 10 on 11/04/15 at 11:50 AM, revealed night shift nurses were responsible for completing daily quality control checks on glucometers and were to document results on the log. LPN #4 stated the purpose of the quality control test was to ensure glucometers were functioning properly. Interview with the Unit Manager of Chandler House, on 11/04/15 at 12:00 PM, revealed the blanks on the Blood Glucose Quality Control log meant quality control tests were not completed daily as directed by facility policy. The Chandler House Unit Manager stated if quality control tests were not completed the glucometer could give a false reading and a resident could receive the wrong dose of insulin. Interview, on 11/04/15 at 3:50 PM, with the Unit Manager of Walters House, revealed quality control tests were to be performed daily on the night shift. The Walters House Unit Manager stated the blanks on the Blood Glucose Quality Control log meant quality control tests were not done. In addition, the Walters House Unit Manager stated it was a standard of practice that all care provided, including quality control testing, be documented. Interview with the Director of Nursing (DON), on 11/05/15 at 8:45 AM, revealed facility policy directed nurses to complete quality control testing daily. The DON stated night shift nurses were instructed during new hire orientation on their responsibility to complete nightly glucometer testing. She stated the blanks on the Blood Glucose Quality Control log meant quality control tests were not completed on those days. The DON stated the glucometers were equipped with the option for a Quality Control (QC) lock mode,	F 456	5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis initiated	12/1/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185388		11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF LOUISVILLE	240 MASONIC HOME DRIVE MASONIC HOME, KY 40041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 11 which did not allow a blood glucose test to be performed unless a control test had been performed in the past twenty-four (24) hours. However the lock mode was not set in all of the glucometers. The DON stated she did not monitor the logs for glucometer testing.	F 456		

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PRINTED: 11/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED
	185388		11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF LOUISVILLE	240 MASONIC HOME DRIVE MASONIC HOME, KY 40041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) BUILDING: 02 PLAN APPROVAL: 2010 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF DP TYPE OF STRUCTURES: Two (2) stories, Type II (222) protected construction. SMOKE COMPARTMENTS: Sixteen (16) total smoke compartments; eight (8) on the First Floor and eight (8) on the Second Floor. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, wet sprinkler system. GENERATOR: Type II 500 KW generator, fuel source is diesel. A Recertification Life Safety Code Survey, utilizing the 2786S Short Form, was conducted on 11/04/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/2/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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