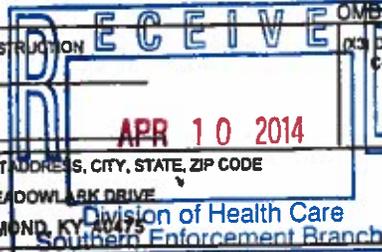


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOD

PRINTED: 04/08/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOW LARK DRIVE RICHMOND, KY Division of Health Care Southern Enforcement Branch	
(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 000	INITIAL COMMENTS	F 000	F281	
F 281 SS=D	<p>An abbreviated standard survey (KY21421) was conducted on 03/11/14. The complaint was substantiated with deficient practice identified at "D" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure services met professional standards of quality for one of three sampled residents (Resident #1). Resident #1 was admitted to the facility on 03/05/14 at approximately 6:30 PM. Interviews revealed at approximately 7:00 PM on 03/05/14, the resident complained of shortness of breath. Interviews and a review of documentation revealed although the resident had physician's orders for medications to treat the resident's complaints of shortness of breath facility staff failed to administer the medication until 9:00 PM, approximately two hours after the resident voiced the complaint. In addition, between 7:00 PM and 8:00 PM on 03/05/14, the resident complained of pain. However, interviews and a review of documentation revealed facility staff failed to administer pain medications to Resident #1 on 03/05/14 as ordered by the resident's physician. According to interviews with facility staff, the resident's medications had not been delivered to the facility at the time of the resident's admission and were not available to administer to treat the</p>	F 281	<p>1. Resident #1 received pain medications and a breathing treatment when the medication from the pharmacy arrived. The physician was notified by the DON relative to when the medications were administered on 3/11/14. Physician provided no new orders. No change in resident status noted.</p> <p>2. All residents have the potential to be affected. A one time audit of all resident's medications which were ordered and required to be in the facility was completed 3/12/14 by the DON, ADON and SDC. No issues were identified. All new admissions beginning 3/12/14 will be reviewed by the DON, ADON, UM or SDC to identify that all medications ordered are in the facility upon resident's arrival. This practice will be ongoing and any issue identified will be immediately reported to the physician. All EDK boxes will be audited by the UMs and pharmacy by 4/9/14 to identify any medications not in the center that are identified to be in the EDK list. Any issues noted will be</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roy L. Barber TITLE: Administrator (X5) DATE: 4/10/14

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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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
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F 281	<p>Continued From page 1</p> <p>resident's complaint of shortness of breath or complaints of pain. Interviews revealed staff was not aware the medications to treat the resident's complaints were available in the facility's "ER box" that contained drugs to use in the event of an emergency. In addition, interviews revealed facility staff failed to notify the resident's physician of the resident's complaints and that the prescribed medications were unavailable to treat the resident's complaints in an effort to obtain alternate treatments/interventions.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Pain," not dated, revealed nursing staff would assess each resident for pain upon admission to the facility and whenever there was a significant change in the resident's condition. However, the policy failed to direct staff on actions to take in the event a resident complained of pain and medications were not available. Interview with the Director of Nursing (DON) on 03/11/14 at 6:10 PM revealed if pain medications weren't available when the resident voiced complaints of pain, staff should notify the resident's physician to obtain new orders to ensure the resident's pain was treated in a timely manner.</p> <p>Continued interview with the DON revealed the facility did not have a policy related to the administration of respiratory treatments to facility residents. However, the DON stated medications were available in the facility's "ER box" at all times to administer respiratory treatments when needed to facility residents.</p> <p>A review of the medical record for Resident #1 revealed facility staff admitted the resident on</p>	F 281	<p>immediately corrected. A one time audit of 25 random existing resident's re-ordered medications for the period of 4/1/14-4/8/14 will be completed by DON, ADON, UM, to identify any medications that were re-ordered and not delivered the day of re-order. This will completed by 4/10/14. Any issues identified will be reported immediately to the MD.</p> <p>3.SDC to re-educate Licensed Nurses regarding professional services/professional standards requiring physician notification if ordered medication is not available, what medications are in the EDK box and physician notification of any change in resident condition. The education to include a post test with a passing score of 80% and to be completed by 4/9/14.</p> <p>DON, ADON or UM to check all new resident's medications list to ensure all medications are available upon resident's arrival, beginning the week of 4/5/14 and ongoing.</p>		

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F 281	<p>Continued From page 2</p> <p>03/05/14 with diagnoses that included Increased Dyspnea Secondary to Congestive Heart Failure, Osteoarthritis, and Chronic Low Back Pain. A Minimum Data Set assessment had not been completed for Resident #1 related to the resident's recent admission, but a review of the Social Services Admission Data Set revealed the resident had been assessed to be independent in daily decision-making.</p> <p>A review of Resident #1's admission physician's orders dated 03/05/14 revealed the resident had orders for staff to administer "Duo Nebs" (medication for the treatment of shortness of breath) every four hours, as needed, for the resident's complaints of shortness of breath. Continued review of Resident #1's physician's orders revealed the resident had orders to receive one 5/325-milligram tablet of Hydrocodone (controlled narcotic pain medication) by mouth, twice daily, as needed for pain.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 03/11/14 at 4:10 PM revealed Resident #1 requested a "breathing treatment" on 03/05/14 "sometime before 7:00 PM" (unable to recall exact time) because he/she "felt smothered." SRNA #1 stated she notified Licensed Practical Nurse (LPN) #1 of the resident's complaints and the resident's request for a "breathing treatment." Continued interview with the SRNA revealed between 7:00 PM and 8:00 PM (unable to recall exact time) on 03/05/14 Resident #1 also complained of lower back pain and requested something for pain. The SRNA stated she notified LPN #1 of the resident's complaint of pain and request for medication.</p>	F 281	<p>DON, ADON, UMs or SDC to audit 5 existing resident's medication list to ensure all medications are available weekly times 4 weeks beginning the week of 4/10/14 times 4 weeks then 3 residents weekly times 2 weeks.</p> <p>SDC to audit and observe 2 nurses weekly providing care, including pain assessments and assessment of respiratory status to ensure all nurses are following professional standards of care beginning the week of 4/10/14 times 4 weeks. The DON will provide all nurses a list of medications in the EDK box by 4/5/14. Any new employed nurse will be given a copy of the list as well beginning 4/5/14 and ongoing. DON, ADON, UM to audit 10 random existing resident's re-ordered medications one time per week beginning the week of 4/13/14. This will be an ongoing system change. DON, ADON, UM to audit EDK box to ensure that all medications identified to be in EDK box are available, once each week.</p>	

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F 281	<p>Continued From page 3</p> <p>LPN #1 acknowledged in interview conducted on 03/11/14 at 4:50 PM she was made aware of Resident #1's complaint of shortness of breath on 03/05/14 at approximately 8:00 PM (unable to recall exact time) and, based on her assessment of the resident, determined the resident "was not in distress." LPN #1 stated she informed the resident his/her medications had not been delivered from the pharmacy and were not available. The LPN stated she was not aware medications for "breathing treatments" were available in the facility's "ER box." LPN #1 also acknowledged she had been informed Resident #1 had complained of pain on 03/05/14 but was unsure of the exact time. The LPN stated the resident's pain medications had not arrived at the facility, therefore medications were not provided to the resident for complaints of pain. Further interview with the LPN revealed she should have contacted the resident's physician related to the resident's complaints of pain and obtained an order for medications that the facility had available. However, the LPN stated she had not contacted the resident's physician because the resident had "no signs of pain."</p> <p>A review of the March 2014 Medication Administration Record (MAR) for Resident #1 confirmed staff had administered a "Duo Nebs" treatment (medication for the treatment of shortness of breath) at 8:00 PM on 03/05/14, approximately two hours after the resident had requested a treatment for his/her complaints of shortness of breath. Continued review of the resident's MAR revealed staff failed to administer pain medications to Resident #1 to treat his/her complaints of pain on 03/05/14.</p> <p>An interview was conducted with Resident #1 on</p>	F 281	<p>This will be an ongoing system change.</p> <p>4. QA team to meet monthly beginning the week of 4/10/14 to review audit findings and revise plan if needed until all issues resolved.</p> <p>5. Date of compliance 4/14/14.</p>	

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F 281	Continued From page 4 03/11/14 at 10:00 AM. Resident #1 stated, "I just can't remember anything about the day I got here." An interview with the facility's Unit Manager, LPN#2, on 03/11/14 at 5:15 PM revealed licensed nurses had been trained that medications were available in the facility's "ER box" and stated LPN #1 should have administered a "breathing treatment" to Resident #1 when the resident complained of shortness of breath on 03/05/14. The Unit Manager further stated LPN #1 should have contacted Resident #1's physician and obtained medications to treat Resident #1's complaints of pain on 03/05/14. An interview with the Director of Nursing (DON) on 03/05/14 at 6:10 PM revealed the facility's "ER box" contained medications to treat breathing problems and stated licensed nurses had been informed of which medications were available. The DON also stated staff should have administered medications in a timely manner to treat Resident #1's complaints of shortness of breath and pain. According to the DON, medications should be provided to facility residents as ordered by the physician and, if medications were not available when a resident requested them, staff should contact the resident's physician for an alternate treatment.	F 281			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425			

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F 425	<p>Continued From page 5</p> <p>law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide pharmaceutical services to include procedures to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of one of three sampled residents (Resident #1). A review of documentation in the medical record revealed the facility admitted Resident #1 on 03/05/14 at approximately 6:30 PM. Documentation revealed the physician had prescribed "Duo Nebs" (medication treatment for shortness of breath) to be administered every four hours as needed for shortness of breath and 5/325 milligrams (mg) of Hydrocodone (controlled narcotic used for pain) by mouth, twice daily, as needed for pain. Interviews with facility staff revealed Resident #1's admission physician's orders were faxed to the pharmacy at approximately 6:30 PM on 03/05/14. A review of the facility's pharmacy</p>	F 425	<p>F425</p> <p>1. Resident #1 received pain medications and a breathing treatment when the medication from the pharmacy arrived. The physician was notified by the DON relative to when the medications were administered on 3/11/14. Physician provided no new orders. No change in resident status noted.</p> <p>2.All residents have the potential to be affected. A one time audit of all resident's medications which were ordered and required to be in the facility was completed 3/12/14 by the DON, ADON and SDC. No issues were identified. All new admissions beginning 3/12/14 will be reviewed by the DON, ADON, UM or SDC to identify that all medications ordered are in the facility upon resident's arrival. This practice will be ongoing and any issue identified will be immediately reported to the physician. All EDK boxes will be audited by the UMs and pharmacy by 4/9/14 to identify any medications not in the center that are identified to be in the EDK list. Any issues noted will be</p>		

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F 425	<p>Continued From page 6</p> <p>services "Proof of Delivery" documentation revealed the pharmacy had dispensed the "Duo Nebs" medication to the facility on 03/05/14 at 9:23 PM (approximately three hours after the resident arrived at the facility), and dispensed the resident's medication for pain to the facility on 03/05/14 at 11:31 PM (five hours after the resident was admitted to the facility). Interviews conducted with facility staff revealed Resident #1 had complained of shortness of breath and pain between 7:00 PM and 8:00 PM (exact time unknown) on 03/05/14. However, interviews and a review of documentation revealed facility staff administered the medication to treat the resident's complaints of shortness of breath at 9:00 PM on 03/05/14, and did not administer any pain medications to the resident on 03/05/14.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on 03/11/14 at 6:10 PM revealed the facility did not have a policy related to pharmaceutical services. According to the DON, the facility's process to acquire prescribed medications was to fax all new admission orders to the facility pharmacy, which was located approximately 30 minutes from the facility. The DON stated a written physician prescription was required to be faxed separately in order for controlled narcotic medications to be dispensed to the facility. The DON also stated all licensed nurses were informed that medications were available in the facility's "ER box" that contained medications for use in emergencies and/or for use when prescribed medications were not readily available.</p> <p>A review of the medical record for Resident #1 revealed facility staff admitted Resident #1 on</p>	F 425	<p>immediately corrected. A one time audit of 25 random existing resident's re-ordered medications for the period of 4/1/14-4/8/14 will be completed by DON, ADON, UM , to identify any medications that were re-ordered and not delivered the day of re-order. This will completed by 4/10/14. Any issues identified will be reported <u>immediately</u> to the MD.</p> <p>All new admissions beginning 4/5/14 will be audited by the DON, ADON, UMs or SCD to identify any medications that require a "hard script" has one and has been faxed to pharmacy. This will be ongoing and any issue identified will be immediately reported to the physician. The DON contacted the pharmacy on 3/12/14 to identify procedures to ensure timely delivery of medications and review facility's responsibility. A one time audit of 25 random existing resident's re-ordered medications for the period of 4/1/14-4/8/14 will be completed by DON, ADON, UM , to identify any medications that were re-ordered and not delivered the day of re-order. This will completed by 4/10/14. Any issues identified will be reported</p>	
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F 425	<p>Continued From page 7</p> <p>03/05/14 with diagnoses that included Increased Dyspnea Secondary to Congestive Heart Failure, Osteoarthritis, and Chronic Low Back Pain. However, a review of the Social Services Admission Data Set revealed the resident had been assessed to be alert and oriented and was independent in daily decision-making.</p> <p>A review of Resident #1's admission orders revealed the physician had ordered staff to administer "Duo Nebs" (aerosol treatment for shortness of breath) to Resident #1 every four hours, as needed, for shortness of breath. Further review of the physician's orders revealed staff was to administer 5/325 mg of Hydrocodone (controlled narcotic used for pain) to the resident twice a day as needed for pain.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 03/11/14 at 4:10 PM revealed Resident #1 stated he/she "felt smothered" and requested a "breathing treatment" at approximately 7:00 PM on 03/05/14 and also complained of lower back pain sometime between 7:00 PM and 8:00 PM. The SRNA stated she notified Licensed Practical Nurse (LPN) #1 of the resident's request for a "breathing treatment" and of the resident's complaints of lower back pain.</p> <p>An interview with LPN #1 on 03/11/14 at 4:50 PM revealed she was informed Resident #1 had complained of shortness of breath on 03/05/14 at approximately 8:00 PM (unable to recall exact time). The LPN stated she informed the resident the medication the physician had prescribed for the resident's shortness of breath was not available at that time. Continued interview with LPN #1 confirmed Resident #1 had also voiced</p>	F 425	<p>3.SDC to re-educate Licensed Nurses regarding professional services/professional standards requiring physician notification if ordered medication is not available, what medications are in the EDK box and physician notification of any change in resident condition. The education to include a post test with a passing score of 80% and to be completed by 4/9/14.</p> <p>DON, ADON or UM to check all new resident's medications list to ensure all medications are available upon resident's arrival, beginning the week of 4/5/14 and ongoing. DON, ADON, UMs or SDC to audit 5 existing resident's medication list to ensure all medications are available weekly times 4 weeks beginning the week of 4/10/14 times 4 weeks then 3 residents weekly times 2 weeks.</p>	

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F 425	<p>Continued From page 8</p> <p>complaints of pain on 03/05/14 but was unsure of the exact time. The LPN stated the resident's medications had not arrived at the facility at that time and were not provided to the resident. Further interview with the LPN revealed Resident #1's "Duo Nebs" breathing treatments arrived at the facility at approximately 9:30 PM on 03/05/14 and at that time the LPN learned the physician's handwritten prescriptions for the resident's narcotic pain medication and an anti-anxiety medication had been "overlooked" and had not been faxed to the pharmacy as required to obtain the medication. Therefore, the facility pharmacy received the resident's handwritten prescriptions by fax at approximately 9:45 PM on 03/05/14, and the resident's medications were delivered to the facility at 11:31 PM (five hours after the resident was admitted). LPN #1 stated, "It usually takes a few hours for medications to arrive to the facility after the orders had been faxed." LPN #1 stated she had not been aware medications, including medications for shortness of breath, were available in the facility's "ER box" when prescribed medications were not immediately available to be administered as requested.</p> <p>A review of the Medication Administration Record (MAR) dated March 2014 revealed facility staff administered Resident #1 a "Duo Nebs" breathing treatment for shortness of breath at 9:00 PM on 03/05/14, approximately two hours after the resident complained of shortness of breath. Continued review of Resident #1's MAR revealed facility staff failed to administer medications to Resident #1 as requested for pain on 03/05/14.</p> <p>An Interview conducted with Resident #1 on 03/11/14 at 10:00 AM revealed the resident stated, "I just can't remember anything about the</p>	F 425	<p>SDC to audit and observe 2 nurses weekly providing care, including pain assessments and assessment of respiratory status to ensure all nurses are following professional standards of care beginning the week of 4/10/14 times 4 weeks. The DON will provide all nurses a list of medications in the EDK box by 4/5/14. Any new employed nurse will be given a copy of the list as well beginning 4/5/14 and ongoing. DON, ADON, UM to audit 10 random existing resident's re-ordered medications one time per week beginning the week of 4/13/14. This will be an going system change. DON, ADON, UM to audit EDK box to ensure that all medications identified to be in EDK box are available, once each week.</p>	

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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(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 425	<p>Continued From page 9 day I got here."</p> <p>An interview with Pharmacist #1 on 03/11/14 at 1:20 PM revealed Resident #1's admission physician's orders were received by "fax" on 03/05/14 at 6:12 PM. The Pharmacist stated the resident's admission orders included orders for 5/325 mg of Hydrocodone (narcotic pain medication) to be administered twice daily, as needed, by mouth. However, the Pharmacist stated facility staff was required to fax a "hard copy" of the prescription for all controlled medications. The Pharmacist stated a hard copy prescription for Resident #1's medications had not been faxed to the pharmacy until 9:42 PM by facility staff on 03/05/14.</p> <p>An interview with LPN #3 on 03/11/14 at 3:50 PM revealed receiving residents' medications timely was "a facility problem, at times." The LPN further stated, "it takes a while to receive medications for residents that are newly admitted."</p> <p>An interview with the Unit Manager (UM), LPN#2, on 03/11/14 at 5:15 PM revealed staff was required to fax orders to the facility pharmacy when residents were admitted to the facility. The UM further stated staff was required to fax a handwritten prescription for "controlled medications" to the facility pharmacy before the pharmacy would dispense the medications to the facility. The UM continued to state licensed nurses had been informed of medications that were available in the facility's "ER box" and stated LPN #1 should have obtained the medication for the resident's complaints of shortness of breath from the "ER box" and administered a "breathing treatment" to Resident #1 when he/she</p>	F 425	<p>Pharmacy to complete a re-education for DON, ADON, UMs and SDC by 4/10/14 regarding accurate acquiring, receiving, dispensing and administration of all drugs/biologicals to meet resident needs upon admission and for existing residents. Pharmacy telephone numbers and after hour numbers to be posted at each nurse's station by 3/12/14 to ensure all nursing staff know how to contact pharmacy, what to do if medications are not immediately available, how to contact the on-call nurse or DON for assistance and physician notification. DON, ADON, UMs to audit 10 random existing resident's re-ordered medications 1 time each week beginning the week of 4/13/14. This will be an ongoing system change. DON, ADON, UMs to audit the EDK boxes to ensure that all medications identified to be in the EDK boxes are available, once per week. This will be an ongoing system change.</p>		

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

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F 425	<p>Continued From page 10</p> <p>complained of shortness of breath on 03/05/14. The Unit Manager further stated LPN #1 should have contacted Resident #1's physician when the medication to treat the resident's complaints of pain on 03/05/14 was not available.</p> <p>An interview with the DON on 03/05/14 at 8:10 PM revealed the pharmacy was required to provide prescribed medications to the facility. The DON further stated if medications were not available when requested, nursing staff should contact the resident's physician. The DON stated the nurse should have obtained medication from the "ER box" and administered a breathing treatment for Resident #1 when requested on 03/05/14, and should have contacted the resident's physician when the resident's pain medication was not available on 03/05/14.</p>	F 425	<p>4. QA team to meet monthly beginning the week of 4/10/14 to review the audit findings and revise plan if needed until all issues are resolved.</p> <p>5. Date of completion 4/14/14.</p>		