

Division of Licensing and Protection

103 South Main Street

Waterbury, VT 05671-2306

<http://www.dail.vermont.gov>

Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

January 20, 2015

Ms. Meagan Buckley, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 22, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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	<p>The following constitutes the facility's response to the findings of the Department of Licensing and Protection and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies.</p> <p>F280 483.20(d)(3), 483.10(k)(2)</p> <ol style="list-style-type: none"> 1. Resident #3 had no negative effects as a result of this alleged deficient practice. 2. Residents with identified nutritional risks have the potential to be affected by this alleged deficient practice. 3. An initial audit will be performed on nutritional care plans for all residents to ensure completion and revision. 4. Education will be provided to licensed nurses and dietitian regarding the requirements for initiating and revising nutrition care plans. 5. Random weekly audits will be conducted by the DNS or designee to monitor the effectiveness of the plan. 6. The results of the audits will be reported to the QAA committee by the DNS or designee monthly x3 months at which time the QAA committee will determine further frequency of the audits. 7. Corrective action to be complete by 1/22/2015. 	
F 280 SS=D	<p>An unannounced on-site complaint investigation concerning quality of care and treatment was conducted by the Division of Licensing and Protection on 12/22/14. The following regulatory violations were identified:</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE. PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to revise a residents' care plan based on identified nutritional risks for 1 of 3 residents (Resident #3). Findings include:</p>	F 280		

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 1/13/2015

Efficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days from 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 from the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 280	<p>Continued From page 1</p> <p>Per 12/22/14 medical record review, Resident #3 was admitted to the facility on 11/21/14 for sub-acute rehab following a fall with a pelvic fracture. On admission, an interim care plan for Nutritional Status/Diet was developed by nursing and included the need for supplements, weekly weights, meal intake monitoring and the determination of likes/dislikes. On 12/1/14, the Registered Dietician (RD) completed a Nutritional Risk Assessment which identified that the resident had a fair to poor appetite, average meal intake of 25-50% and a BMI of 18.7 (<18.5 is considered underweight; 18.5-24.99 is considered normal). The RD documented that the resident was "at risk for [weight] loss and skin breakdown related to fair-poor oral intake as evidence by < 50% of intake and stating poor oral intake on a daily basis." Additionally, the resident was reported to state that s/he "eats/drinks very little. Avoids food w/chemical, wheat and milk." On 11/24/14, Resident #3 weighed 110 pounds, on 11/29/14 102.4 pounds and on 12/2/14 102.4 pounds (a weight loss of 7.6 pounds). On 12/22/14 at approximately 2:20 PM, the facility RD stated that supplements were offered to the resident, but declined based on personal tastes/preferences. The RD confirmed that there was no documentation in Resident #3's medical record that supplements were offered and confirmed that there was no evidence that the original nursing nutrition care plan was revised to address the residents' weight loss (whether related to fluid or body weight loss), refusal of supplements, additional weight checks, or other possible interventions. (Refer F281, F514)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p>	F 280	FABC POC accepted 11/15/15 SDEM/APP/PMU	
-------	---	-------	---	--

281 IS=D

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

475014

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

12/22/2014

NAME OF PROVIDER OR SUPPLIER

BURLINGTON HEALTH & REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

300 PEARL STREET

BURLINGTON, VT 05401

(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 281

Continued From page 2

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to assure that nursing staff met professional standards of practice regarding accurately performing 1. fall risk and 2. skin assessments and 3. failed to reweigh a resident at recommended intervals after weight loss was identified for 1 of 3 residents in the sample (Residents #3) Findings include:

1. Per 12/22/14 medical record review, Resident #3 was admitted to the facility on 11/21/14 for sub-acute rehab following a fall with a pelvic fracture. On 11/21/14, nursing staff completed a fall risk assessment which identifies a residents' risk for falls based on criteria that includes a history of falls, ambulation/elimination status, gait and balance issues, vision status, medication use and predisposing diseases. Each risk factor is assigned a point value and the numbers are totaled to obtain a fall risk score. A staff nurse calculated Resident #3's total fall risk score as "2" which indicates a low risk for falls. However, per review of the risk assessment form, the nurse miscalculated and the total fall risk score should have been 10. A score of 10 or greater indicates a high risk for falls and is flagged in the medical record to alert staff of the risk. On 12/22/14 the Sub-acute rehab UM confirmed that Resident #3's fall risk assessment score was not accurate and did not identify the residents' risk for falls.

2. On 11/21/14 a nursing staff member completed a skin assessment for Resident #3 and

F 281

F281 483.20(k)(3)(i)

1. Resident #3 was not affected by the alleged deficient practice.
2. Residents at risk for falls, compromised skin integrity, and weight loss have the potential to be affected by the alleged deficient practice.
3. An initial audit will be conducted by DNS or designee to ensure all fall, skin, and nutritional evaluations are completed

correctly.

4. Staff education will be provided to licensed nurses and dietitian on accurate completion of fall, skin, and nutrition evaluations.
5. Random weekly auditing will be conducted by DNS or designee to evaluate the effectiveness of the plan.
6. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.
7. Corrective action will be complete by 1/22/15.

Fall POC accepted 1/15/15 SDennis APR/1/15

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

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 281	<p>Continued From page 3</p> <p>documented that the resident had a Stage I pressure ulcer on his/her coccyx (tail bone area). A Stage I pressure ulcer is identified by intact skin with "non-blanchable redness" of a localized area usually over a bony prominence. However, on the 11/21/14 corresponding nurses' progress note, the coccyx skin is described as a "2 x 2 cm, pink, blanchable" area. On a follow-up skin assessment on 12/2/14, the staff nurse documented Resident #3 as having a Stage II pressure ulcer on his/her coccyx. A Stage II pressure ulcer is defined as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed. However, the nursing progress note for 12/2/14, documented that the resident's coccyx skin was "pink, 2 x 1 cm, blanchable." On 12/22/14 the Sub-acute rehab UM (Unit Manager) confirmed that Resident #3 did not have a pressure ulcer and that the skin assessment completed by the staff nurse was not accurate.</p> <p>3. Per 12/22/14 medical record review, on 12/1/14, the facility's Registered Dietician (RD) completed a Nutritional Risk Assessment which identified that Resident #3 had a fair to poor appetite, average meal intake of 25-50% and a BMI of 18.7 (<18.5 is considered underweight; 18.5-24.99 is considered normal). The RD documented that Resident #3 was "at risk for [weight] loss and skin breakdown related to fair-poor oral intake as evidence by < 50% of intake and ... poor oral intake on a daily basis." Per the medical record, on 11/24/14, Resident #3 weighed 110 pounds; on 11/29/14 102.4 pounds; and on 12/2/14 102.4 pounds (a weight loss of 6.9% or 7.6 pounds from the time of admission). On 12/1/14 the RD wrote in a progress note, "wt loss 8# in 5 days [...] please obtain rewt, then wt</p>	F 281		

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
---	---	--	--

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 281	<p>Continued From page 4</p> <p>daily x 2 days." On 12/6/14, the RD wrote in another progress note, "Showing wt loss of 8# since 11-24. Please obtain rewt then continue daily wts x 3 days to monitor wt status." On 12/22/14 at approximately 3:40 PM, the Sub-acute rehab UM reported that the additional weight measurements were not obtained by nursing staff as the RD's recommendation for weight rechecks in a progress note was not an established system of communication to nursing staff. The resident was only weighed at weekly intervals and not as recommended by the RD. (The resident was hospitalized on 12/7/14). (Refer F514, F280)</p> <p>Lippincott Manual of Nursing Practice, 9th Edition Page 17 Standards of Professional Nursing Practice</p> <p>514 483.75(l)(1) RES SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and medical record review,</p>	F 281	<p>F514 483.75(l)(1)</p> <ol style="list-style-type: none"> 1. Resident #3 was not affected by the alleged deficient practice. 2. Residents at risk for falls, compromised skin integrity, weight loss, and those taking antibiotic medication have the potential to be affected by the alleged deficient practice. 3. An initial audit will be conducted by DNS or designee to ensure all fall, skin, and nutritional evaluations are completed and follow up documentation regarding supplements and antibiotic medication is completed and accurate. 	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 514	<p>Continued From page 5</p> <p>the facility failed to assure that the clinical record for 1 of 3 residents (Resident #3) was complete and accurate. Findings include:</p> <p>1. Per 12/22/14 medical record review, Resident #3 was admitted to the facility on 11/21/14 for sub-acute rehab following a fall with a pelvic fracture. On 11/21/14, nursing staff completed a fall risk assessment which identifies a residents' risk for falls based on criteria that includes a history of falls, ambulation/elimination status, gait and balance issues, vision status, medication use and predisposing diseases. Each risk factor is assigned a point value and the numbers are totaled to obtain a resident's fall risk score. The facility nurse calculated Resident #3s' total fall risk score as 2 which indicates a low risk for falls. However, per review of the risk assessment form, the nurse miscalculated the score and the total risk score should have been 10. A score of 10 or greater indicates a high risk for falls and is flagged in the medical record to alert staff of the fall risk. The miscalculation and inaccurate score for fall risk was confirmed by the Sub-acute rehab UM (Unit Manager) on 12/22/14 at approximately 3:00 PM.</p> <p>2. On 11/21/14 a nursing staff member completed a skin assessment for Resident #3 and documented that the resident had a Stage I pressure ulcer on his/her coccyx (tail bone area). A Stage I pressure ulcer is identified by intact skin with "non-blanchable redness" of a localized area usually over a bony prominence. However, on the 11/21/14 nursing progress note, the coccyx skin is described as a "2 x 2 cm, pink, blanchable" area. On a follow-up skin assessment on 12/2/14, the staff nurse documented Resident #3 as having a Stage II pressure ulcer on his/her</p>	F 514	<p>4. Staff education will be provided to licensed nurses and dietitian on accurate completion of fall, skin, and nutrition evaluations as well as complete and accurate documentation and follow up regarding supplements and antibiotic medication.</p> <p>5. Random weekly auditing will be conducted by DNS or designee to evaluate the effectiveness of the plan.</p> <p>6. The results of the audit will be reported to the QAA committee monthly X3 months at which time the QAA committee will determine the frequency of further auditing.</p> <p>7. Corrective action will be complete by 1/22/15.</p> <p><i>F514 POC accepted 1/15/15 Dennis APN/PNC</i></p>	
-------	--	-------	---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 514	<p>Continued From page 6</p> <p>coccyx. A Stage II pressure ulcer is defined as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed. However, the nursing progress note for the same day, documented that the resident's coccyx was "pink, 2 x 1 cm, blanchable." On 12/22/14 the Sub-acute rehab UM confirmed that Resident #3 did not have a pressure ulcer and that the documentation on the skin assessment forms was not accurate.</p> <p>3. On 11/22/14 Resident #3 was prescribed Levaquin 500mg one tablet daily for 7 days for an elevated temperature and symptoms of pneumonia. (Levaquin is an antibiotic). Per review of a nursing progress note dated 11/28/14, a staff nurse documented, "Continues with PO [by mouth] abx for cellulitis without adverse reaction." On 12/22/14 the Sub-acute rehab UM confirmed that the clinical note was not accurate and that the resident did not have cellulitis but was completing a course of antibiotics for pneumonia.</p> <p>4. On Resident #3's 11/21/14 admission, an interim care plan was developed that included a Nutritional status/Diet care plan. The resident was checked to have "supplements" in addition to his/her diet due to his/her poor appetite. On 12/22/14 at approximately 2:20 PM, the facility dietician stated that supplements were offered to the resident, but declined based on personal tastes/preferences. The dietician confirmed that there was no documentation in Resident #3's electronic or paper record to confirm that supplements were offered and the medical record was not complete.</p> <p>Per 12/22/14 interview, the UM confirmed the above documentation irregularities and did not</p>	F 514		
-------	---	-------	--	--

PRINTED: 12/31/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BURLINGTON HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 300 PEARL STREET BURLINGTON, VT 05401
---	---

(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 514	Continued From page 7 provide evidence that the irregularities had been identified or corrected by the time of the survey. (Refer F280, F281)	F 514		
-------	---	-------	--	--