

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

PRINTED: 07/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185208</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/08/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 CARMEL MANOR ROAD FORT THOMAS, KY 41075</b>
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(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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>A Recertification Survey was conducted 07/06-08/10, and a Life Safety Code Survey was conducted 07/08/10. Deficiencies were cited, with the highest scope and severity of a "F".</p> <p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity as evidenced by eye drops being administered to two (2) unsampled residents in the dining room, during lunch on 07/06/10.</p> <p>The findings include:</p> <p>Observation of the lunch meal service on 07/06/10 at 12:52 PM revealed Registered Nurse (RN) #2 administered eye drops to two (2) unsampled residents in the dining room.</p> <p>Interview on 07/08/10 at 12:30 PM with RN #2 revealed the facility's policy stated eye drops were to be administered in the resident's room, a bathroom or the nurse's station. Further interview revealed eye drops were not to be administered in the dining room.</p> <p>Interview on 07/08/10 at 1:00 PM with RN #1, the</p>	F 241	<p>Facility will continue to promote care for residents in a manner that promotes each resident's dignity.</p> <p>All residents are moved to their room or nurses station for administration of eye drops. Nurse Manager immediately informed nursing staff that medications are to be administered in private.</p> <p>Other residents having orders for eye drops were identified and monitored by the Nurse Manager to ensure these medications were given in privacy.</p> <p>Policy and procedures on medication pass observation and resident dignity will be reviewed and revised by the Director of Nursing.</p> <p>An in-service was conducted by Nurse Manager with RN#2 on 7/22/10 regarding resident dignity and administration of eye drops. A complete medication pass observation was conducted with RN#2 by Nurse Manager.</p> <p>An all staff in-service will be conducted on 8/12/10 by Education Director regarding resident dignity.</p>	8/17/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sister Teresa Kennedy</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-10-10</i>
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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 241	Continued From page 1 Unit Manager revealed it was against policy to instill eye drops in the dining room, the residents should have been taken to a private area before the eye drops were administered. Further interview revealed RN #2 needed more training regarding policies.  Interview on 07/08/10 at 1:30 PM with RN #5, the Director of Nursing (DON), revealed, according to policy, the eye drops should have been administered in a private area of the facility, not in the dining room. The DON stated it was a dignity and privacy issue.	F 241	A Quality Assurance monitor will be developed and implemented on resident dignity and medication administration. It will be conducted by the Director of Nursing or designee 2 x week x 4 weeks, weekly x 4 weeks, bi-weekly x 8 weeks and then monthly. See Quality Assurance audit F24	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY.  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store, prepare, and distribute food in a sanitary manner. Holding temperatures were not maintained at 140 degree or greater, there were glasses and lids on the floor behind the ice machine in the satellite kitchen, there was a visible accumulation of dust inside the grill, and food particles were observed under the steamer in the main kitchen.	F 371	The facility will continue to store, prepare and distribute food in a sanitary manner.  (F371-1) Kitchen floor was thoroughly swept and mopped.  Food particle on kitchen floor had no effect on food served to residents from serving pantry.  Policy and procedure on cleaning and kitchen sanitation will be reviewed and revised by the Dietary Director.  An in-service was conducted with all cooks by the Dietary Director on 8/5/10 to review the cook's cleaning schedule.  A Quality Assurance monitor on cleaning schedule and end of shift cleaning duties will be developed and implemented by Dietary Director weekly x 3 months and then monthly. See Quality Assurance audit F371-1.	8/16/10

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F 371	<p>Continued From page 2</p> <p>The findings include:</p> <p>1. Observation for three (3) days of the survey revealed food particles under the steamer. Interview, on 07/08/10 at 2:38 PM, with the Dietary Manager revealed the facility had a list of designated cleaning tasks to be completed each day. Additionally, she stated the supervisors were to ensure tasks were completed as scheduled. The Dietary Manager stated the food item under the steamer looked like "Riblet".</p> <p>Review of the "Cook Cleaning Schedule" revealed the kitchen floor was to be swept and mopped at the end of each shift.</p> <p>2. Observation of the tray line, on 07/07/10 for the lunch meal, revealed holding temperatures had already been taken by dietary staff. Review of the temperature log revealed the starch "tatter tots" were recorded as 110 degree Fahrenheit (F). The dietary aide served five (5) residents "tatter tots".</p> <p>Interview, on 07/07/10 at 12:05 PM, with the Dietary Manager revealed the serving line served both personal care and nursing facility residents. In additional interview the Dietary Manager stated the holding temperature for the "tatter tots" should be 140 degrees F. The Dietary Manager had not reviewed the temperature log prior to staff serving the food.</p> <p>Interview, on 07/07/10 at 12:06 PM, with the dietary aide serving residents revealed she had not taken the temperatures prior to serving the food. She explained another dietary aide had taken the temperatures.</p>	F 371	<p><b>(F371-2)</b> Temperatures will continue to be taken at each meal and holding temperatures on hot foods will be greater than 140 degrees.</p> <p>Other residents were not affected as evidenced by Dietary Director replaced the tater tots on the serving line with tater tots temped at 150 degrees.</p> <p>Policy and procedure on food temperatures will be reviewed and revised by the Dietary Director.</p> <p>An in-service will be conducted by the Dietary Manager with the dietary staff on food temperatures.</p> <p>A Quality Assurance monitor will be developed and conducted by the Dietary Director on food temperatures daily x 7, weekly x 8 and then monthly. See Quality Assurance audit F371-2.</p>	
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F 371	<p>Continued From page 3</p> <p>Interview, on 07/07/10 at 12:07 PM, with Dietary Aide #2 who had taken the holding temperatures revealed she had not identified the temperature of the "tatter tots" as a problem.</p> <p>3. Observation of the grill during three (3) days of the survey revealed there was visible build up of dust on the gas lines inside the opening on the face plate of the grill.</p> <p>Interview, on 07/08/10 at 2:38 PM, with the Dietary Manager revealed the facility had a list of designated cleaning tasks to be completed each day. Additionally, she stated the supervisors were to ensure tasks were completed as scheduled.</p> <p>Review of the "Cook Cleaning Schedule" revealed the ovens and stove tops were to cleaned inside and out after each use.</p> <p>4. Observation of the serving kitchen for the long term care unit, on 07/07/10 at 4:15 PM and 07/08/10 at 2:34 PM, revealed cups and lids were on the floor behind the ice maker.</p> <p>Interview, on 07/08/10 at 2:34 PM, with Dietary Aide #3 revealed the floor was to be swept after each meal. She stated the cups and lids should have been cleaned after the breakfast meal, as that was when the floor around the ice maker was cleaned.</p> <p>Interview, on 07/08/10 at 2:38 PM, with the Dietary Manager revealed the facility had a list of designated cleaning tasks to be completed each day.</p>	F 371	<p><b>(F371-3)</b> Grill was thoroughly cleaned on 7/8/10.</p> <p>Dust had no effect on food served to residents as it was inside the grill. The grill was not used for food preparation during the survey.</p> <p>Policy and procedure on cleaning and kitchen sanitation will be reviewed and revised by the Dietary Director.</p> <p>An in-service was conducted with all cooks on 8/5/10 by the Dietary Director to review the cook's cleaning schedule.</p> <p>A Quality Assurance monitor on cleaning schedule and end of shift cleaning duties will be developed and implemented by Dietary Director weekly x 3 months and then monthly. See Quality Assurance audit F371-1.</p> <p><b>(F371-4)</b> Kitchen floor was thoroughly swept and mopped.</p> <p>Residents were not affected as cups and lids were discarded.</p> <p>Policy and procedure on cleaning and kitchen sanitation will be reviewed and revised by the Dietary Director.</p> <p>An in-service was conducted with all cooks by the Dietary Director on 8/5/10 to review the cook's cleaning schedule.</p>	
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F 371	Continued From page 4 Review of the facility's "Cleaning Schedule" revealed the ice machine was to be cleaned after each meal. Additionally, the floor was to be swept and mopped after each meal.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	The facility will continue to maintain control of medications for residents to insure accurate dispensing of controlled drugs.  Upon identification of the medication at bedside, nurse went to resident's room and identified which medication was at bedside. Nurse administered medication and remained with resident as she took the medication.  Nurse Manager did a room check to ensure no other medications were left at bedside. Staff was instructed that if any medications were found at bedside to notify Nurse Manager or Director of Nursing immediately.  Policy and procedures on self administration of medication will be reviewed and revised by the Director of Nursing.  Policy and procedure on medication administration will be reviewed and revised by Director of Nursing.  An in-service was held with LPN #4 on 7/22/10 regarding proper method of dispensing controlled drugs. A complete medication pass observation was conducted with LPN #4 by Nurse Manager.	8/18/10

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F 431	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain control of medications for one (1) of fifteen (15) sampled residents (Resident #9).</p> <p>The findings include:</p> <p>Record review revealed Resident #9 was admitted 04/29/06 with diagnoses which included Cardiomyopathy, Anemia, Rheumatoid Arthritis, Depression, Personality Disorder, Behavioral Disorder, Anxiety, Conduct Disturbance, Gastroesophageal Reflux Disease (GERD) and Muscle Disuse. Further review revealed the facility assessed the resident to have moderate cognitive impairment, was verbally abusive and resistant to care at times.</p> <p>Observation on 07/07/10 at 7:10 AM revealed an unlabeled tablet, in a medication cup, on the resident's bedside table. The resident revealed he/she was unable to self-administer the pills due to contracted fingers and drowsiness in the mornings.</p> <p>Interview on 07/07/10 at 7:55 AM with Licensed Practical Nurse (LPN) #4, Charge Nurse revealed the tablet was Carafate (an antacid) and should not have been left at the bedside. Further interview revealed the medication should have been taken in front of the nurse who administered it.</p> <p>Interview on 07/08/10 at 10:55 AM with Registered Nurse (RN) # 6 revealed she gave the</p>	F 431	<p>An in-service will be conducted by the Education Director for all nursing staff on medication administration and self administration of medications.</p> <p>A Quality Assurance monitor on medication administration will be developed and conducted by Director of Nursing or designee weekly x 4 and then monthly. See Quality Assurance audit F431.</p>	

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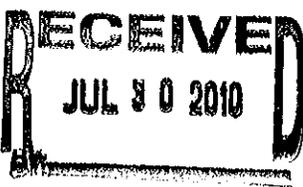
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F 431	<p>Continued From page 6</p> <p>medication to the resident at 6:30 AM. Further interview revealed the policy stated that nurses were to watch residents take their medications.</p> <p>Interview on 07/08/10 at 11:02 AM with RN #1 revealed the facility's policy stated nurses have to watch residents take their medications, it was against policy to leave medications at the bedside.</p> <p>Interview on 07/08/10 at 1:30 PM with the Director of Nursing (DON) revealed the policy stated the nurse had to stay with the resident until the medications were swallowed therefore, it was against policy to leave the medications in the resident's room.</p>	F 431			

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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 07/08/2010. The facility failed to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure fire drills were conducted according to NFPA standards.  The findings include:  Record review on 07/08/2010 at 4:45 PM, revealed the facility had not conducted the required fire drills for 3rd shift during the 4th quarter of 2009. Further record review revealed that the facility had conducted 1st shifts 4th quarter drill as a verbal drill. The fire drill was conducted at 10:00 AM. The Maintenance Director was present during record review.	K 050	Facility will continue to insure that fire drills are conducted at unexpected times and at least quarterly each shift.  No drills will be held between 6 am and 9 pm using a coded announcement instead of the fire alarm signal.  Documentation for all fire drills will be completed on a timely basis by Maintenance Director.  Policy and procedure on fire drills will be reviewed and revised.  In-service will be conducted by Administration with the maintenance department to review policy and procedure on fire drills.  A Quality Assurance monitor will be developed and implemented on fire drills, documentation, frequency and mode of announcement. It will be conducted by the Maintenance Director monthly x 3 and then quarterly.	7/8/10  7/8/10  7/8/10  8/5/10  8/13/10  8/13/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cindy Dullaghan</i>	TITLE <i>Assistant Administrator</i>	(X8) DATE <i>7-28-10</i>
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K 050	Continued From page 1  Interview on 07/08/2010 at 4:45 PM, with the Maintenance Director, revealed that he had conducted the fire drills for 3rd shift as required but he could not find the documentation. Further interview with the Maintenance Director, revealed that he was not aware that only fire drills conducted between 9:00 PM and 6:00 AM could be verbal fire drills.  Reference: NFPA 101 (2000 edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that cooking facilities were maintained according to NFPA standards.	K 069	The fryer was moved on 7/8/10 to a distance of 21 inches from the cooking stove. Ample space was available.  A steel baffle plate was installed between the fryer and the cooking stove on 7/30/10.  Policy and procedure on cooking facilities and required separation between appliances will be reviewed and revised.	7/8/10  7/30/10  8/6/10

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K 069	Continued From page 2  The findings include:  Observation on 07-08-10 at 6:00 PM, revealed that a deep fryer was adjacent to a gas cooking stove with no separation or shield in place. The Maintenance Director was present during the observation.  Interview on 07-08-10 at 6:00 PM, revealed the Maintenance Director was not aware of the required separation or shield for the cooking appliances.  Reference: NFPA 96 (1998 edition) 9-1.2.3 All deep fat fryers shall be installed with at least a 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.	K 069	In-service will be conducted by the Maintenance Director with maintenance staff and Dietary Director on required separation between appliances.  A Quality Assurance monitor will be developed and implemented by the Maintenance Director on required separation between appliances weekly x 4, monthly x 3 and then quarterly.	8/13/10  8/13/10
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on interview and record review it was	K 144	Generator will continue to be inspected weekly and exercised under load for 30 minutes per month. This will be properly documented.  Maintenance Director will continue to conduct weekly inspections on generator and will document accordingly.  Policy and procedure on generator inspection and load testing will be reviewed and revised as needed.	7/8/10  7/8/10  8/6/10

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185208</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/08/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 CARMEL MANOR ROAD FORT THOMAS, KY 41075</b>
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K 144	<p>Continued From page 3</p> <p>determined that the facility failed to ensure that the emergency generator was inspected according to NFPA standards.</p> <p>The findings include:</p> <p>Record review on 07/08/10 at 5:15 PM, revealed that the facility could not produce documented evidence of the maintenance checks for the emergency generator's batteries for the third week of February 2010 and the first week of March 2010.</p> <p>Interview on 07/08/10 at 5:15 PM, with the Maintenance Director, revealed that he does the weekly checks for the emergency generator but did not document the weeks that were missing.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p>	K 144	<p>In-service will be conducted by Administration with the Maintenance Director on generator inspection, load testing and documentation.</p> <p>A Quality Assurance monitor on generator inspection, load testing and documentation will be developed and conducted by the Maintenance Director weekly x 4, monthly x 3 and then quarterly.</p>	<p>8/13/10</p> <p>8/13/10</p>

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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 CARMEL MANOR ROAD FORT THOMAS, KY 41075</b>
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K 144	<p>Continued From page 4</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p>	K 144		
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