STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

(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 STANDARD SURVEY 10/7/2020 CENSUS: 119 SAMPLE SIZE: 24 plus 2 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		10/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/22/2020

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F 756	Continued From page 1 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Consultant Pharmacist reviewed initial medication orders upon admission. This deficient practice was identified for 6 of 7 residents (Residents #114, #113, #71, #115, #89, and #109) reviewed on the [redacted] unit, and was evidenced by the following: 1. Resident #114 was admitted to the [redacted] nursing unit of the facility for [redacted] on [redacted] with diagnoses that included [redacted]. The resident's care plan included a "Focus" of "I wish to return home in the community following completion of [redacted]" with "Date initiated: [redacted]	F 756	1. Residents 71, 89, 109, 113, 114, 115 were affected by the deficient practice. All missing Drug Regimen Reviews were sent to the Consultant Pharmacy, completed and reviewed by the attending. There were no negative outcomes. 2. All new admissions have the potential to be affected by the deficient practice. An audit was completed on all new admissions from September 16 to present to assure that initial Drug Regimen Reviews were completed. No additional missing reviews were found. 3. The Director of Nursing will re-educate all nurses on the Drug Regimen Review Process. The system has been upgraded to automatically notify the Consultant Pharmacy that a review is needed. 4. An audit will be completed by the Director of Nursing or Assistant Director of Nursing weekly x4 then monthly x3 to monitor compliance. The Director Of	

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F 756	Continued From page 2 A review of the resident's medical records revealed a [redacted] at 14:33 (2:33 PM) Progress Note that noted, "patient was recently hospitalized, now presents for [redacted]. The [redacted] Progress Note included "Rehab Goals: Safe Discharge" and "d/c (discharge) plan for home." The resident's admission "Order Summary Report" included physician orders for the resident to receive medications that included [redacted] During a further review of the resident's medical record, the surveyor was unable to find documentation that the Consultant Pharmacist (CP) had reviewed the resident's admission physician's orders. When interviewed on 10/5/20 at 11:00 AM, the Director of Nursing (DON) said the initial CP medication review was not done. The DON said a form was completed by the facility that indicated the list of medications had been sent to the CP, but there was no confirmation that it had been received. The DON said that when questioned, the CP said it had not been received. When interviewed on 10/5/20 at 12:20 PM, the DON said, "when someone is admitted, the list of medications are faxed over to the CP, then an email is sent from the CP which goes to the Unit Manager and the DON. When a chart review is done, we make sure it's been sent and received and check the next day to see if it got there. This one was missed." When interviewed on 10/7/20 at 11:40 AM, the	F 756	Nursing will report the results to the QA Committee quarterly. The QA Committee consists of the Nursing Home Administrator, Director Of Nursing and Medical Director.	

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F 756	Continued From page 3	F 756		

Director of Nursing said that the [redacted] nursing unit was their [redacted], and anyone coming in from the hospital for [redacted] would go to the [redacted]. The DON said it was their procedure that upon admission, the list of medications would be faxed to the CP by either the admitting nurse or the nursing supervisor, depending on the time the resident was admitted.

2. Resident #113 was admitted to the [redacted] nursing unit of the facility for [redacted] on [redacted] with diagnoses that include [redacted] The resident's care plan included a "Focus" of "I wish to return home in the community following completion of [redacted] with "Date Initiated: [redacted]"

A review of the resident's medical records revealed a Progress Note dated [redacted] at 14:06 (2:06 PM) that included, "Rehab Goals: Safe Discharge." Additionally, the [redacted] 13:18 (1 :18 PM) Progress Note noted, "Patient was recently hospitalized, now presents for [redacted]

The resident's admission "Order Summary Report" included physician orders for the resident to receive [redacted]).

During further review of the resident's medical record, the surveyor was unable to find documentation that the CP had reviewed the resident's admission physician's orders. On

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F 756	Continued From page 4 10/7/20 at 10:40 AM, the DON confirmed that the initial CP medication review had not been done. The DON said, "it was done when the CP came in, which was late." 3. Resident #71 was admitted to the [redacted] nursing unit of the facility for [redacted] with diagnoses that included [redacted]. The resident's care plan included a "Focus" of "I wish to return home in the community following completion of [redacted] with "Date initiated: [redacted] A review of the 8/14/20 at 11:36 AM Progress Note included "transferred to WS (Willow Springs) for [redacted] and "Rehab Goals: Safe Discharge." The resident's admission "Order Summary Report" included physician orders for the resident to receive medications that included [redacted]). During further review of the resident's medical record, the surveyor was unable to find documentation that the CP had reviewed the resident's admission physician's orders. On 10/7/20 at 10:40 AM, the DON confirmed that the initial CP medication review had not been done.	F 756		

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F 756	Continued From page 5 The DON said, "it was done when the CP came in, which was late." 4. Resident #115 was admitted to the [redacted] nursing unit of the facility for [redacted] 0 with diagnoses that included [redacted]. The resident's care plan included a "Focus" of "I wish to discharge to (name of an Assisted Living Facility) following completion of [redacted] with "Date initiated: [redacted] An 8/28/20 at 11:11 AM Progress Note included "transferred to WS for [redacted]." And a [redacted] at 12:43 PM Progress Note documented, "d/c plan for (facility name) ALF." The resident's admission "Order Summary Report" included physician orders for the resident to receive [redacted]. During a review of the resident's medical record, the surveyor was unable to find documentation that the CP had reviewed the resident's admission physician's orders. On 10/7/2020 at 10:40 AM, the DON confirmed that the initial CP medication review had not been done. The DON said, "it was done when the CP came in, which was late." 5. Resident #89 was admitted to the [redacted] nursing unit of the facility for [redacted] with diagnoses that included [redacted] Following	F 756		

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F 756	Continued From page 6	F 756		

[redacted].
The resident's care plan included a "Focus" of "I wish to return home in the community following completion of [redacted] with "Date initiated: [redacted]"

A 9/10/20 at 11:51 AM Progress Note included "transferred to WS for [redacted]" and "Rehab Goals: Safe Discharge."

The resident's admission "Order Summary Report" included physician orders for the resident to receive [redacted].

During a review of the resident's medical record, the surveyor was unable to find documentation that the CP had reviewed the resident's admission physician's orders. On 10/7/20 at 10:40 AM, the DON confirmed that the initial CP medication review had not been done. The DON said, "it was done when the CP came in, which was late."

6. Resident #109 was admitted to the [redacted] nursing unit of the facility for [redacted] with diagnoses that included [redacted]. The resident's care plan included a "Focus" of "I wish to return home alone in the community" with "Date initiated: [redacted]

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F 756	Continued From page 7 A review of the [redacted] at 11:50 AM Progress Note included "transferred to WS for [redacted]" And a [redacted] at 10:49 AM Progress Note included "d/c plan for home alone." The resident's admission "Order Summary Report" included physician orders for the resident to receive [redacted] During a review of the resident's medical record, the surveyor was unable to find documentation that the CP had reviewed the resident's admission physician's orders. On 10/7/20 at 10:40 AM, the DON confirmed that the initial CP medication review had not been done. The DON said, "it was done when the CP came in, which was late." The surveyor reviewed the facility's policy titled "Medication Regimen Reviews" dated "Revised April 2007, Adopted-March 2016," which included, "Reviews for short-stay individuals will be done as needed to identify individuals with high-risk medications and those who may be experiencing adverse consequences from their medications. The surveyor reviewed the facility's policy, "Pharmacy Services-Role of the Consultant Pharmacist" dated "Revised April 2007, Adopted-March 2016," which included "the facility will inform the Consultant Pharmacist of	F 756		

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F 756	Continued From page 8 all new admissions and readmissions to the facility." NJAC 8:39-27.1(a)	F 756		
F 761 SS=B	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain emergency carts that were clean and contained up to date supplies. This deficient practice was identified for 2 of 2 emergency carts	F 761	1. No residents were affected by this deficient practice. Both Crash Carts located in Dining Rooms were cleaned and all items□ expiration dates were checked. Any outdated items were	10/28/20

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F 761	Continued From page 9 located in 2 of 2 main dining rooms and was evidenced by the following: On 10/2/2020 at 9:11 AM, the surveyor observed an emergency cart in the [redacted] main dining room. The emergency cart included an [redacted], and supplies for use with residents or staff in the event of a medical emergency. The cart was a white PVC style frame with shelves and had a gray mesh cover. The surveyor lifted the cover to observe the items on the emergency. The surveyor observed that the top of the [redacted], on the top shelf, was dusty. The surveyor was able to remove dust when wiped with a finger. The top shelf, which contained packaged supplies for use with the [redacted] was also dusty. In addition, on the top shelf, the surveyor observed (4) [redacted]." The surveyor observed that all four bottles of the [redacted] had an expiration date of "5/11/20." The surveyor observed that all four bottles of [redacted] had an expiration date of "6/27/20." There was a thin binder on the second shelf of the cart, and when reviewed, the surveyor observed that it contained an "Emergency Code Cart Inventory List" dated October 2020. The surveyor observed that for 10/1 and 10/2, initials had been written indicating that the cart had been checked as noted at the bottom of the form, "CHECKING EMERGENCY CODE CART, PLEASE INITIAL NEXT TO EACH ITEM."	F 761	replaced 2. All residents have the potential to be affected. All crash carts were cleaned, and expiration dates were checked. 3. The Director of Nursing revised the Crash Cart Check List to include need for cleaning & check expiration dates. DON will re-educate all nurses as it relates to Crash Cart Check List process. 4. The Unit Managers/Nursing Supervisor will audit weekly x4 and monthly x 3 months to monitor compliance. The DON will report results to the QA Committee quarterly. The QA Committee consists of the NHA, DON and Medical Director.	

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F 761	Continued From page 10 On 10/2/2020 at 9:21 AM, the surveyor observed the emergency cart in the [redacted] main dining room. The cart was the same PVC style frame with shelves and had a gray mesh cover as the other emergency cart noted above. The suction machine on the top shelf was dusty, with the surveyor being able to wipe the dust off with a finger. The white PVC style frame's top rim had areas that were not clean with a brown substance that came off with the surveyor's fingernail. The top shelf contained (4) 100 ml bottles of [redacted] " The surveyor observed that all four bottles of the [redacted] had an expiration date of "5/11/20." The surveyor observed that all four [redacted] had an expiration date of "6/27/20" (same as the other emergency cart as noted above). The cart also had the binder with an October sheet that had initials for being checked on 10/1 and 10/2. When interviewed on 10/3/2020 at 9:45 AM, the Director of Nursing (DON) said the 11 (PM) to 7 (AM) supervisory was responsible for checking the emergency carts in the main dining rooms daily. The DON said the procedure would be to check the inventory list to ensure everything listed was there, replace any missing items, and check the dates of all products. The DON provided the surveyor with the inventory check sheet for September 2020, which also had been initialed daily. NJAC 8:39-27.1 (a) NJAC 8:39-31.4 (a)	F 761		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/28/20

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F 812 SS=E	Continued From page 11 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner. This deficient practice was evidenced by the following: On 10/1/20 from 8:36 to 9:26 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. There were two bags of frozen hash brown	F 812	1. No residents were affected by the deficient practice. The hash browns were immediately discarded. The dessert plates were immediately removed and re-cleaned and sanitized. The ice scoop was removed from service, cleaned and sanitized. The Dietary aide who was found inappropriately handling the dish machine and hand washing was immediately educated and the dish machine was rerun. The employee who left the scoop in the ice machine was educated. 2. All residents have the potential to be affected by the deficient practice. An	

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F 812	Continued From page 12 potatoes, individually placed in separate plastic bags, suspended from the post of a multi-level rack in the walk-in freezer. The bags were labeled with a date of 3-17. When interviewed at that time, the FSD stated, "They were put in here on 3-17. They are good for six months." The FSD removed the two bags of hash brown potatoes and threw them in the trash. 2. There were four stacks of salad/dessert plates stored in a plastic bin on the portable steam table. Of the four stacks of plates, three were exposed on the eating surface and not inverted. When interviewed, the FSD stated, "They should be covered when not in use. I will have them cleaned and sanitized again." 3. The surveyor opened the ice machine door and observed a blue, plastic scoop in the ice bin. When interviewed, the FSD stated, "That shouldn't be in there, one of our ice machines on the unit broke, and staff is getting ice for the unit from us. They must have left the scoop in there." On 10/7/2020 from 9:29 to 9:49 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen: 1. The surveyor observed the operation of the high-temperature dish machine after the breakfast meal. At 9:33 AM, the surveyor observed the Dietary Aide (DA) unloading cleaned and sanitized dishware from the high-temperature dish machine while wearing disposable gloves. The DA then walked over to the unwashed/dirty area of the dish room and proceeded to scrape and rinse dirty dishware. The DA loaded the dirty dishes into a dish rack while wearing the same disposable gloves. At	F 812	audit was completed on all food stored in the freezer to assure that none are past shelf life. No additional were found. An audit was completed on dishes to ensure that all were covered. Any found uncovered were re-washed and sanitized. All ice machines in the facility were audited to assure that the scoop was stored correctly. 3. The Director of Food Service will re-educate all Food Service Staff on safe hand washing, appropriate procedures for the dish machine, shelf life of stock items, cross contamination, and sanitary procedures. 4. A detailed kitchen audit that includes a checklist of the items cited as well as items covered within the educations provided will be completed by the Food Service Director or Administrator weekly x4 then monthly x3 to monitor compliance. The Nursing Home Administrator and Food Service Director will report results to the QA Committee quarterly.	

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9:37 AM, the DA then walked back over to the cleaned and sanitized side of the dish machine, still wearing the same disposable gloves, and removed cleaned and sanitized pellet lid/covers (a plastic lid used to cover a plate of food in foodservice operations) from the cleaned and sanitized dish rack after the pellets had exited the high-temperature dish machine.

The DA then proceeded to the designated handwashing sink. The DA removed his soiled gloves, threw them in the trash, turned on the faucet, and proceeded to place both hands under running water for approximately 5 seconds. The DA then grabbed a paper towel, dried his hands, and turned off the faucet with the paper towel. The DA threw the paper towel in the trash can and proceeded to don a new pair of disposable gloves. When interviewed on proper handwashing, the DA stated, "You turn on the water, soap your hands, wash for as long as it takes to sing happy birthday, grab three towels and dry the hands. Then turn the faucet off with the towel and throw it away." When asked if he had washed his hands for a full 20 seconds as instructed by the sign posted on the wall above the designated handwashing sink, the DA stated, "No."

On 10/6/2020 at 12:20 PM, the Administrator provided the surveyor with a "Hand Washing Competency" evaluation dated 7/13/2020. When reviewed, the surveyor observed that the DA had met all handwashing requirements at that time.

The surveyor reviewed the facility policy titled "Ice Machines and Ice Storage Chests," revised January 2012. The policy included the following under Policy Interpretation and Implementation:

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2. "To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions:"

e. "Keep the ice scoop/bin in a covered container when not in use."

The surveyor reviewed the facility policy titled "Refrigerators and Freezers," revised December 2014. The policy included the following under the Policy Interpretation and Implementation heading:

7. "All food shall be appropriately dated to ensure proper rotation by expiration dates. "Received" dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. "Use by" dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened."

8. "Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired, or past perish dates."

The surveyor reviewed the facility policy titled Handwashing/Hand Hygiene", revised August 2014. The policy included the following under Policy Interpretation and Implementation:

1. "All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections."

2. "All personnel shall follow the

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handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."

9. "The use of gloves does not replace hand washing/hand hygiene. Integration of glove use, along with routine hand hygiene, is recognized as the best practice for preventing healthcare-associated infections."

The policy also included the following under the heading "Washing Hands":

1. "Vigorously lather hands with soap and rub them together, creating a friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water at a comfortable temperature. Hot water is unnecessarily rough on hands."

2. "Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to the inside of the sink."

3. "Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."

4. "Discard towels into trash."

5. "Use lotions throughout the day to protect the integrity of the skin."

The surveyor reviewed the facility policy titled "Dishwashing and Machine Use," revised March 2010. The policy included the following under Policy Interpretation and Implementation:

1. "The following guidelines will be followed when

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F 812	Continued From page 16 dishwashing:" a. "Wash hands before and after running dishwashing machine, and frequently during the process." NJAC 8:39-17.2 (g)	F 812		
F 868 SS=B	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide documented evidence on sign-in sheets that the facility's Medical Director was in attendance at the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was identified for 11 of 14 (QAA/QAPI) meetings reviewed and was evidenced by the following:	F 868	1. No resident was affected by this deficient practice. The Medical Director attested that he reviewed all meeting minutes. 2. All residents have the potential to be affected. 3. The nursing home administrator re-educated the Medical Director about his responsibilities to the QAA Committee.	10/28/20

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F 868	Continued From page 17 On 10/5/2020 at 10:30 AM, the surveyor reviewed the notes and sign-in sheets for the facility's monthly QAA/QAPI meetings. The surveyor reviewed the sign-in sheets for the following months of the year 2019: 5/29/19, 6/25/19, 7/17/19, 9/4/19 (for the 8/2019 meeting), 9/25/19, 10/29/19, 11/26/19, and 12/31/19. Of those meetings, the sign-in sheets included a signature for the Medical Director for the 7/17/2019 meeting only. The surveyor also reviewed the sign-in sheets for the following months of 2020: 1/7/20, 2/25/20 (no sign-in sheets for 3/2020, 4/2020, or 5/2020), 6/30/20, 8/7/20 (for the 7/2020 meeting), 8/28/20, and 10/1/20. Of those 14 QAA/QAPI meetings, there was only documented evidence on the sign-in sheets that the facility's Medical Director (MD) was in attendance for 7/17/2019, 1/7/2020, and 10/1/2020. On 10/5/20 at 10:44 AM, the surveyor interviewed the facility's Administrator about the missing signatures of the Medical Director for the 11 of 14 meetings held during this year and the previous year (2020-2019). The Administrator stated, "The Medical Director hasn't been here because of COVID-19." When the surveyor asked if the Medical Director was at the meeting via Zoom or telephone call, the Administrator stated, "No, but he reviews all the notes from the meeting." The surveyor reviewed the facility's policy "Quality Assurance Performance Improvement Plan," undated. The policy noted, "All department	F 868	4. The nursing home administrator will audit QAA Sign in sheets to assure that Medical Director attends and signs all QAA Committee Meetings. The Director Of Nursing will report results to the QA Committee quarterly. The QA Committee consists of the Nursing Home Administrator, DON and Medical Director.	

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F 868	Continued From page 18 managers, the administrator, the director of nursing, infection control and prevention officer, a nursing assistant, medical director, consulting pharmacist, resident and/or family representatives (if appropriate) and additional general staff will provide QAPI leadership by being on the QAA committee" and "The QAA committee will meet monthly." NJAC 8:39 33.1(b)	F 868		