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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING ______ B. WING ______	C 09/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD CARE CENTRE	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

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F 000	INITIAL COMMENTS Dementia Care Focused Survey	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that there was a medical symptom for the use of a physical restraint. The facility failed to develop and implement a reduction plan for the use of a physical restraint. This applies to 2 of 2 residents (R2, R3) reviewed for restraint use in the sample of 6. The findings include: 1) R2's September, 2014 Physician's Order Sheet documents that R2's diagnoses includes Dementia. The same order sheet shows an order that reads; may use self-releasing restraint while up in wheelchair due to impaired cognition, decreased safety awareness, impulsive behaviors and to improve quality of life. R2's Minimum Data Set (MDS) assessment shows that R2 has cognitive impairment. (Short and long term memory problems) R2 requires extensive assistance of one person for transfer. R2 is frequently incontinent of bladder and bowel.	F 221		

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

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 221	Continued From page 1 She was assessed to be at risk for pressure ulcer development. The Physical Restraint assessment of 8/4/14 documents that R2 has an unsteady gait, agitated behavior, frequent falls and attempts to self -transfer. The same assessment documents that R2 has impaired safety awareness and inability to self ambulate and transfer. R2 has a self releasing belt in place and has the ability to release it (belt) on command. R2 has Dementia and inability to make safe decisions and the safety belt is used to enhance her quality of life. The documentation shows that no reduction attempts have been made this past quarter per the POA's (Power of Attorney) request due to a fractured hip. The recommendations were to continue the self releasing belt to enhance R2's quality of life. R2 is able to release the belt on command. R2's Fall Risk Care Plan dated through 11/4/14 shows that R2 is a high risk for falls related to being unaware of her safety needs. The goal is documented as, R2 will use the self releasing safety belt to prevent injury. The approaches include that R2 will have her belt released to change positions, meal times, and during activities. On 9/2/14 R2 was at lunch, and on 9/3/14 at breakfast. R2 was wearing the safety belt during both of the meal times. On 9/2/14 at 3:00 PM, R2 was observed in an activity. R2 was wearing her safety belt during the activity. R2 was wheeling her around the room, and nearly running over the toes of R7. R7 was pushing her away and raising her feet to avoid R2 from running over her toes with the wheel chair.	F 221		

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F 221	Continued From page 2	F 221		

R7 said "your running over my feet, that hurts my toes."

On 9/3/14 at 10:30 AM, E3 (Licensed Practical Nurse) was asked about R2's safety belt. At this time, R2 was in an activity of ball toss, she was wearing her safety belt. E3 said it was her expectation that the safety belts are released during structured activities and meals.

On 9/2/14 at 2:10 PM, E4 (Certified Nursing Assistant) was asked to demonstrate how R2 removes her safety belt on command. E4 placed R2's hands on the buckle of the belt and showed her how to release it. She then asked R2 several times to take it off and R2 fiddled with the belt and was unable to remove it. E4 said she would remove it for her.

According to the facility Physical Restraint Protocol physical restraints will only be used in the facility when it is determined they are required to treat a medical symptom.
The same document shows that a physician's order will be obtained that includes the type, medical symptom, diagnosis, and when to apply and release. Trials of alternatives will be conducted at least quarterly.

2) During initial tour on 9/2/14 between 11:40 AM and 12:30 PM, R3 was observed sitting up in the wheelchair. R3 was alert, cooperative but confused to place and time. R3 was in the dining room and assisted with lunch meal. At 3:30 PM, R3 was observed in the bed. Two CNAs (Certified Nursing Assistants) entered the room and provided hygiene care to R3. After providing the personal care, the CNAs transferred R3 to the wheelchair via total mechanical lift. The CNA

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F 221	Continued From page 3 applied the seat belt turned the wheelchair so that R3 faced the window and left the room. R3 was calm and did not attempt to move or get out of the wheelchair. On 9/2/14 at 5:08 PM, the staff wheeled R3 to the dining room and placed in front of the table in preparation for the supper time. At 5:40 PM, R3's family member came and fed the resident. The staff did not release R3's seat belt during supper meal. On 9/3/14 at 7:00 AM, R3 was observed sitting in the wheelchair with the seat belt fastened in front of the resident. At 7:15 AM, R3 was wheeled in the dining room and placed in front of the dining table. R3 remained alert, cooperative and conversant. E9 (Assistant Director of Nursing) assisted R3 with breakfast meal. E9 did not release R3's seat belt during the meal. E2 (Director of Nursing) stated on 9/3/14 at 2:30 PM that R3's seat belt is self releasing and not considered a restraint. The Progress Notes dated 6/13/14 showed that R3 had a vest restraint and replaced with self release belt and with encouragement, R3 was able to release the belt. The notes also showed that R3 will be monitored for safety. There was no assessment for appropriate use of the seat belt or follow up regarding the continued use of the belt. There was no documented medical symptom for the use of the seat belt. There was no comprehensive care plan to address specific use of R3's seat belt.	F 221		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 4	F 279		

COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record review the facility failed to develop a comprehensive plan of care with specific interventions to address a residents behavior and communication concerns.
This apply to 1 of 6 residents (R4) reviewed for comprehensive care plans in the sample of 6.
The findings include:
R4 was originally admitted to the facility on 6/2/14 with multiple diagnoses which included Advanced Dementia/Alzheimers and Dementia with behavioral disturbance documented on the resident's facesheet.

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F 279	Continued From page 5 R4's progress notes dated 6/3/14, 6/24/14, 6/27/14, 7/16/14 and 9/2/14 showed documentation that the resident spit out her medications. The progress notes dated 6/5/14 shows, "pt. uncooperative and not taking meds." On 6/8/14, the facility documented, "Per CNA (Certified Nursing assistant), Resident was resistive to care this am, hitting, pinching, screaming and crying." On 8/23/14, the facility documented, "spitting out meds hitting staff." R4's initial MDS (Minimum Data Set) dated 6/15/14 shows a BIMS (Brief Interview for Mental Status) score of "14," indicating that the resident is cognitively intact. The Section B of the MDS showed no problem making self understood and no problem understanding others. The Section E of the same MDS showed that R4 exhibited behavioral symptoms directed toward others (e.g., hitting) and that R4 also exhibited other behavioral symptoms not directed toward others. These behavioral symptoms according to the MDS occurred 1 to 3 days. R4's CAA (Care Area Assessment) dated 6/15/14, under Psychosocial Well-Being showed that R4's primary language is Spanish and that the resident speaks limited English. R4 exhibits behavior of resisting care with combativeness at times. Can be re-approached but interferes with provision of care and may place caregivers in harms way. This CAA indicated that care plan was not considered to address this problem. R4's CAA dated 6/15/14, under Cognitive Loss/Dementia showed that the resident exhibits behavior of resisting care with combativeness and may place caregivers in harms way. This CAA indicated that, "unexplainable behavior may be attempt at communication about pain, toileting needs, uncomfortable position, etc." and documented the need to address this problem in the care plan.	F 279		

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F 279	Continued From page 6 R4's CAA dated 6/15/14, under Behavior Symptoms showed that the resident exhibits behavior of resisting care with combativeness and may place caregivers in harms way. This CAA indicated that R4 is an immediate threat to others and that there is a need to address this behavior. The above mentioned CAA's were completed by E7 (Social Service Director). On 9/2/14 at 3:15 PM, R4 was inside the room with Z3 (Spouse). R4 was in her wheelchair, confused, with garbled speech and was unable to express needs. Z3 stated that R4 is able to respond better when spoken to in Spanish. On 9/3/14 at 7:00 AM, R4 was in her wheelchair outside her room, in front of the nursing station. R4 was confused, with garbled speech and was unable to express needs. In an interview held on 9/2/14 at 2:24 PM, E5 (CNA) stated that most of the time R4 is resistive to ADL (activities of daily living) care, including dressing, brushing teeth and hair, incontinence care and transfers. Per E5, R4 would hit and pinch staff during provision of care. E5 stated that R4 speaks Spanish only and that she would communicate to the resident in English. E5 also stated that she does not ask other staff to help interpret for the resident and that there is no available communication board or card to help communicate with R4. In an interview held on 9/3/14 at 10:00 AM, E6 (Nurse) stated that R4 would often spit out her medications and is normally resistive to care. E6 stated that R4 speaks Spanish only and that she would communicate to the resident in English. E6 also stated that she does not ask other staff to help interpret for the resident and that there is no available communication board or card to help communicate with R4. In an interview held on 9/3/14 at 10:30 AM, E7	F 279		

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F 279	Continued From page 7 (Social Service Director) stated that he is not aware of R4's resistive to care and aggressive behavior. E7 also stated that he is aware that R4 speaks Spanish but is able to understand some/simple English. Per E4, there is no care plan in place to address R4's behavior and communication problem. R4's records showed no care plans in place to address the resident's resistive to care and aggressive behavior towards staff, there was no care plan in place to address R4's communication problem and there was no care plan in place to address R4's Cognitive Loss/Dementia.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280		

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F 280	Continued From page 8	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview the facility failed to review and revise the care plan to reflect the residents current level of care.

This applies to 1 of 6 residents (R2) reviewed for care planning in the sample of 6.

The findings include:

R2's September, 2014 Physician's Order Sheet documents that R2's diagnoses includes Dementia. The same order sheet documents R2's diet as Regular, ground meats.

R2's Minimum Data Set (MDS) assessment of 7/31/14 shows that R2 has cognitive impairment. (Short and long term memory problems) R2's cognitive functioning level was unable to be evaluated.

R2's Nutritional Care Plan dated through 11/4/14 documents R2 has a potential for nutritional problem related to her Dementia. The goal is that R2 will comply with the recommended diet for weight reduction through the next review date. The approaches include: started on Remeron due to depression and weight loss. Dietary restrictions of mechanical soft foods.
Another care plan for the use of antidepressant medication dated through 11/4/14 documents that R2 is on antidepressant medication related to poor nutrition, decreased appetite and weight loss.

R2's Cognitive loss care plan dated through 11/4/14 documents that R2 will improve her

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F 280	Continued From page 9 current level of cognition by next review. R2 will remain oriented to person, place, situation, time through next review. R2's risk of abuse care plan documents the goal for R2 is to remain safe and express feelings of security in relation to her husband. Her communication care plan shows that she has a communication problem related to dementia and cognitive decline. She does not always understand what is said to her and has difficulties expressing her needs. These care plans are dated through 11/4/14. R2's Urinary Incontinence care plan dated through 11/4/14 documents that R2 is unable to communicate her needs. On 9/2/14 at 2:50 PM, R2 was in an activity. She was wheeling her wheelchair around the group aimlessly. She was running over the toes of another resident (R7) R2 was observed to fall asleep at intervals. In the same activity R2 was observed to remove her shoe, place it on her lap, and fiddle around with the shoe laces. On 9/2/14 at 4:30 PM, R2 was taken to another room for a ball toss activity. She wheeled her chair into the corner and was facing a table with her back to the group. She would attempt to move but her wheel chair brakes were locked. On 9/3/14 at 7:30 AM, R2 was in the assisted dining room, she was unable to determine what to do with her food. She would put some hot cereal on her spoon them, remove it from the spoon with her finger and lick it off her finger. She held a boiled egg for some time in her hand, would lay it back down, and pick it back up. She repeated this	F 280		

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F 280	Continued From page 10 behavior several times. When staff told her it was a boiled egg and she should eat it she said " I can't because there is something inside it." Prior to the breakfast being served R2 was observed pushing her wheel chair away from the table and wheeling into a cabinet that was next to the table. She repeated wheeling her chair into the cabinet, despite not being able to move.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have effective interventions to provide necessary personal care to a resident with Dementia. This applies to 1 of 6 residents (R2) reviewed for dementia care in the sample of 6. The examples include: R2's September, 2014 Physician's Order Sheet documents that R2's diagnoses includes Dementia. R2's Minimum Data Set (MDS) assessment of 7/31/14 shows that R2 has cognitive impairment.	F 309		

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F 309	Continued From page 11	F 309		

(Short and long term memory problems)
The same assessment shows that R2 requires extensive assistance of one for transfers. R2 is incontinent of of bladder and bowel. R2 is at risk for development of pressure ulcer.

On 9/2/14 at 2:10 PM, E4 (Certified Nursing Assistant) was asked to demonstrate how R2 removes her safety belt on command. E4 placed R2's hands on the buckle of the belt and showed her how to release it. She then asked R2 several times to take it off and R2 fiddled with the belt and was unable to remove it. E4 said she would remove it for her. E4 was attempting to toilet R2. E4 released R2's safety belt, placed a gait belt around R2's waist. E4 attempted several times to instruct R2 to stand up, and where to place her hands. R2 would start to stand up and grasp for something to hold on to for her balance, she would then sit back down in the chair. After several repetitions of this E4 was unable to toilet R4. E4 said that R2 usually transfers herself. E4 said she will stand and get on the toilet if she had to go.
R2 was then taken to a craft activity. R2 wheeled her wheel chair around the group during the craft activity, ran over the toes of another resident. (R7) R2 remained in the activity room until 4:30 PM.
At 4:30 PM, E8 (Activity Aide) took R2 to another room and started another activity.(balloon toss) R2 wheeled her wheel chair out of the circle and into a cabinet by the window. Her wheel chair brakes were on, and she continued to struggle to move her wheel chair, despite being blocked by the table.
At 5:00 PM E10 (CNA) was asked to assist in an observation of R2's skin.

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F 309	Continued From page 12	F 309		

E10 was unable to transfer R2 out of her wheel chair. She said "she's not going to let me."
E11 (CNA) came to assist E10, E11 went to get a stand lift. When E10 and E11 placed the stand lift sling under R2 and positioned the lift, R2 could not follow the instruction to hold on to the bars. As E10 and E11 lifted R2 the sling would go up under her arms and she would cry to stop. E10 and E11 were unsuccessful at transferring R2 to the toilet and to change her incontinent brief. E11 said that E12 (CNA) could not get R2 to transfer earlier that day.

At 6:20 PM, E13 CNA entered R2's room and placed a gait belt on R2 in an attempt to get R2 to stand up from her wheel chair and sit on the toilet. E13 said she was looking to see if there was a walker in R2's room so she would have something to hold onto. She said that sometimes its easier to transfer residents if they have something to hold. There was no walker available in R2's room. R2 was able to gain the cooperation of R2 to stand and remove a very foul smelling incontinent brief. (intense ammonia smell permeated the room)
R2's wheel chair had no pressure reducing cushion on it. E13 was not working on the Dementia unit that evening she came from the 2 south unit to assist R2.

On 9/3/14 at 12:00 PM, Z2 said that when R2 is at home (visits) he uses safety bars, and a high rise toilet seat. Z2 said he is able to transfer R2 to the toilet in this manner without difficulty. Z2 said he installed a safety bar at home for R2 to hold onto to assist in transfers.

On 9/3/14 at 10:30 AM, E3 (Licensed Practical Nurse) said that her expectation is that staff

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	145908	A. BUILDING ______ B. WING ______	C 09/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD CARE CENTRE	2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103

(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 309	Continued From page 13 would have come to get her to assist in order to provide personal care to R2. (transfer, toileting, and incontinence care) E3 said that R2 has no pressure reducing wheel chair cushion because she pulls it out. E3 said she gave her a floral one, instead. R2 was in a group activity at this time and E3 verified there was no floral cushion or pressure reducing wheel chair cushion on R2's chair.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop non-pharmacological approaches for a resident with adverse behaviors prior to initiating a mood-altering medication. This applies to 1 of 6 residents (R5) reviewed for psychotropic medication use in a sample of 6. The findings include: R5 ' s Physician ' s Order Sheet dated September 2014 shows that R5 has a diagnosis of Dementia. R5 ' s Nurse ' s Notes (NN) show that R5 was admitted to the facility on 8/15/14. On 9/2/14 at 2:45PM, R5 was assisted to the bathroom, at 4:35PM R5 was participating in the activity, at 5:50PM R5 was in the dining room waiting for dinner. No adverse behaviors were observed. The NN dated 8/15/14 state, " (R5) has been very agitated this PM. Very argumentative ... Refused to have vitals taken. Has been verbally threatening staff and telling staff members that he was going sue them and they would be going to jail. Needed to be a one on one due to his constantly trying to get out of wheelchair. " R5 ' s hospital discharge orders dated 8/15/14 show that a new prescription for Haloperidol was given to R5 upon discharge from the hospital. The NN dated 8/16/14 state, " Orders-Administration Note: Haloperidol (Antipsychotic) Tablet 1 mg. Give 1 mg by mouth four times a day related to Dementia, unspecified without behavioral disturbance. Patient refused this medication stating, " I don ' t take any medications and I don ' t belong here! " The NN dated 8/18/14 state, " Wife and daughters here. Very concerned about behaviors, agitation and medications. Reassurance given	F 329		

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F 329	Continued From page 15 that MD will see this week and he will check over meds and make changes as needed. " The NN dated 8/18/14 state, " Seen by (Physician) today with new orders to discontinue Haldol and multivitamin. No increase in behaviors noted today. Pleasant, eating well and taking fluids well. Participating in activities. " The NN dated 8/21/14 state, " This RN relayed that (R5) had been complaint in taking his meds, eating breakfast and using his wheelchair consistently this AM. Reported to caller that patient has been far less oppositional and argumentative and had not been physically aggressive toward staff or other residents ... " R5 ' s Behavior Summary Reports dated for the weeks ending 8/23/14 and 8/30/14 show that R5 had 4 behaviors of " rejection of care " and 2 behaviors of " threatening behavior " in the 2 week period. The NN dated 8/25/14 state, " (Physician) here to see due to severe sun downing with inability to redirect. New orders received to start Depakote (Anticonvulsant also used for Bipolar Disorder) 125 mg twice a day. " R5's Interim Care plan dated 8/16/14 does not document any behaviors for the use of a psychotropic medication nor does it document any non-pharmacological approaches used for behavior management. On 9/3/14 at 2:30 PM, E2 (Director of Nursing) stated, " (R5) was on Haldol when he was admitted and we got him off of it. His behaviors continued so we started Depakote. " The undated facility policy entitled, Psychotropic Program states, " The facility also on a daily basis monitor identified behavior changes through the behavior tracking form and the nurse ' s notes. Staff report new behaviors to resident ' s charge nurse. Non- pharmacy interventions are	F 329		

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F 329	Continued From page 16 tried first. "	F 329		