

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 14TH STREET, SE WASHINGTON, DC 20003</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)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from September 29, 2011 through September 30, 2011. A sample of three clients was selected from a population of one male and five women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations and interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.

[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]

W 104 483.410(a)(1) GOVERNING BODY

W 104

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:  
Based on observation and interview, the governing body failed to ensure the van used to transport the residents was maintained in good repair for six of six residents in the facility.  
(Clients #1, #2, #3, #4, #5 and #6)

The finding includes:

The facility failed to ensure repairs were made to the van used for transportation of the residents, as evidenced below:

*Received 10/24/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Spney Stephen</i>	TITLE  <i>President</i>	(X6) DATE  <i>10/24/11</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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W 104	Continued From page 1  On September 30, 2011, at 8:06 a.m., staff was observed taking the residents to the rear of the facility to board the van to depart for their day programs. Clients #1, #2, #3, #4, and #6 were assisted onto the van by staff. Client #5, in his wheelchair, was placed on the lift, loaded into the back of the van, and his wheelchair was then secured to the floor.  At 8:11 a.m., additional observations revealed the following:  a. The edges of the vinyl floor covering were rolled upward in the passenger seating area.  b. One of the rivets necessary to secure the floor covering in place at the van passenger entrance door was missing.  These concerns created potential trip hazards.  c. On the front passenger side of the van (door area), the rubber gasket installed on the body of the van was partially detached. Staff was observed to push it back in place, prior to closing the door.  d. The inner lining of the left rear door of the van had a large hole in it, which was approximately nine inches in diameter. This allowed the metal on the door to be exposed where the hole was located.  These concerns created a potential for poor temperature control during cold weather.  On September 30, 2011, at 8:32 a.m., interview	W 104	a. The Vinyl floor covering was repaired on 10-21-11. 10-21-11. b. The rivets were repaired on 10-21-11. 10-21-11  c. The rubber gasket was replaced on 10-21-11. 10-21-11  d. The inner lining of the rear door was replaced on 10-21-11. 10-21-11. The Q.I.D.P and House Manager will keep a maintenance log on a weekly basis to ensure that repairs are completed in a timely manner.  See Attachment "F"

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W 104	Continued From page 2 with the staff failed to determine when the aforementioned concerns were first observed by the facility. Interview with the qualified intellectual disabilities professional (QIDP) revealed the van had been leased by the facility for several years and that the concerns identified had occurred over time, due to continuous use.  At the time of the survey, the governing body failed to provide ongoing monitoring to ensure that the van was maintained in good repair.	W 104	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for three of three clients in the sample. (Client #1, #2, and #3)  The findings include:  1. On September 29, 2011, at 4:35 p.m., evening observations revealed Client #1 sitting in a chair in his bedroom with both feet elevated holding a newspaper. Further observations revealed the client wearing ted stockings that stop just below the knee. At 4:52 p.m. and 5:56 p.m., Client #1 was observed sitting in his room watching television with both legs elevated. After dinner at 6:50 p.m., the client's feet remained elevated while sitting. Interview with Staff #1 on the same day at 6:52 p.m. revealed Client #1's feet were to	W 120	1. The Day Program staff was trained on 10-18-11 on 10-18-11 on individual's feet elevation protocol with emphasis on the exceptions during meal time and for activities lasting not more than 15 minutes. The Q.I.D.P will make weekly visits to day program for one month and follow up with monthly visits to ensure that the Day Program staff are implementing the protocol on a consistent basis.  (See Attachment "A1-A3")
			10-18-11

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W 120	<p>Continued From page 3 remain elevated while sitting due to his edema.</p> <p>On September 29, 2011, at 1:07 p.m., observations conducted at the day program revealed Client #1 sitting in his classroom looking through a newspaper with both legs placed on the floor. Continued observations from 1:08 p.m. to 1:38 p.m. revealed the client remained seated in a chair with his feet on the floor. During this time, the client alternated between playing the guitar and turning the pages of his newspaper.</p> <p>On September 30, 2011, at 10:23 a.m., review of the medical records revealed physician's orders (POS) dated September 2011. The POS revealed the client had a diagnosis of Intermittent Pedal Edema. Further review of the POs revealed to keep Client #1's legs elevated while seated during the day time.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 30, 2011, at 1:39 p.m. and 1:54 p.m. respectively revealed that the facility provided the day program with a foot stool to ensure his feet were elevated. Further interview revealed that the day program had a copy of the current physician's orders and a copy of the foot stool protocol dated January 1, 2011.</p> <p>At the time of the survey, the day program failed to ensure that Clients #1's feet were elevated during the day as prescribed.</p> <p>2. On September 29, 2011, at beginning at 6:04 p.m., Client #3 was observed calmly seated in the sitting room on the couch with her feet elevated. The client remained with her feet elevated until</p>	W 120		



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W 120	<p>Continued From page 5</p> <p>support of staff. The client was observed seated in a chair at the table as he ate his snack. At 6:31 p.m., the client was observed at the table in a chair eating dinner. Client #2 was not observed to use his wheelchair once he arrived home from the day program.</p> <p>On September 30, 2011, at 9:45 a.m., review of the physical therapy meeting summary note dated March 2, 2011, indicated that while at the day program, Client #2 should be transferred from the wheelchair to a regular chair while in the classroom or dining area. Further review revealed the client's wheelchair should only be used for long distances.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 30, 2011, at approximately 10:00 a.m., revealed the physical therapist and the QIDP trained the day program staff on the use of Client #2's wheelchair on March 8, 2011.</p> <p>At the time of the survey, the day program failed to ensure that Client #2 sat in a regular chair as recommended by the physical therapist.</p> <p>4. On September 29, 2011, at 1:48 p.m., Client #2 was observed engaging in conversations with his teacher and his classmate. At 1:57 p.m., the day program staff opened a bag of crackers and handed the crackers to Client #2. The client then began to eat his crackers without washing or sanitizing his hands. Interview with the house manager on September 30, 2011, revealed that the day program should have had Client #2 wash his hands before he consumed his food.</p>	W 120	<p>The Q.I.D.P will visit the day program weekly for two weeks and then monthly for two months and continue quarterly visits.</p> <p>(See attachment "D")</p> <p>4. The Day Program staff was trained 10-20-11 on health care associated infections and the importance of hand washing at all times especially when handling food. The Q.I.D.P will make weekly visits to the day program for two months and then monthly to ensure that the physicians order and protocols for all individuals are implemented consistently.</p> <p>(See attachment "C")</p>	<p>monthly &amp; quarterly</p> <p>10-20-11</p>

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W 120	Continued From page 6 There was no evidence that proper infection control procedures were implemented at the day program.	W 120		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each staff was effectively trained on infection control procedures, for one of three clients included in the sample. (Client #1)  The finding includes:  Cross refer to W455. The facility failed to ensure effective infection control procedures were implemented for Client #1 during snack time.	W 189	The residential staff was retrained on 10-07-11 by the Director of Nursing on infection control. The Q.I.D.P, House Manager will monitor staff on a daily basis for two months and then monthly to ensure that the staff is knowledgeable. (See Attachment <b>A</b> )	10-07-11
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain in good repair, clients' adaptive equipment as	W 436		

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W 436 Continued From page 7  
recommended, for one of the three clients in the sample. (Client #2)

The finding includes:

The facility failed to ensure Client #2's walker was maintained in good repair, as evidenced below:

On September 30, 2011, at 4:31 p.m., Client #2 was observed ambulating with a four wheel walker in the facility. The walker was observed with duck tape that covered the majority of the seat and on the side bars. The walker was also observed with worn brake cables, but the brakes were still functional. On September 29, 2011, at approximately 5:30 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that he was aware that Client #2's four wheel walker was in need of repair.

On September 30, 2011, at 12:03 p.m., review of Client #2's physical therapy assessment dated August 29, 2011, revealed the client used the walker to ambulate for short distances. It should further be noted that the record failed to evidence any documentation that repairs were to be completed.

At the time of the survey, there was no evidence that facility maintained Client #2's walker in good repair.

W 436

A new four wheel rolling walker was purchased by the Agency on 10-03-11 for individual # 2. Medicaid had declined paying for a rolling walker for this individual. Medicaid could only pay for a wheelchair for him. Q.I.D.P and House Manager will monitor condition of adaptive equipment weekly. All needed repairs will be reported timely to the Program Manager for needed follow up.  
(See Attachment "E")

10-03-11

W 455 483.470(l)(1) INFECTION CONTROL

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

W 455

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W 455 Continued From page 8

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure effective infection control procedures were implemented, for one of three clients included in the sample. (Client #1)

The finding includes:

Observations on September 29, 2011, at approximately 4:38 p.m., Staff #1 picked up Client #1's newspaper off the floor. A few minutes later, Staff #1 placed her hands inside a box and gave them to the client without washing her hands. At 5:10 p.m., interview with Staff #1 confirmed that she did not wash her hands prior to serving Client #1 his snack. Further interview revealed that she had received training on infection control procedures.

Review of the in service training records on September 30, 2011, at approximately 3:00 p.m., revealed that all staff had received training on infection control on September 14, 2011. At the time of the survey, there was no evidence, however, that the training to prevent infectious diseases had been effective.

W 455

The residential staff was retrained on 10-07-11 by the Director of Nursing on infection control. The Q.I.D.P, House Manager will monitor staff on a daily basis for two months and then monthly to ensure that the staff is knowledgeable. (See Attachment A)

10-07-11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2011</b>
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1 000	INITIAL COMMENTS  A licensure survey was conducted from September 29, 2011 through September 30, 2011. A random sampling of three residents was selected from a population of five males and one female with varying degrees of intellectual and developmental disabilities.  The findings of this survey were based on observations at the group home and three day programs, interview direct support staff and management, and a review of the habilitation and administrative records including unusual incident reports.	1 000	<p style="text-align: center;"><i>Received 11/02/11</i></p> <p style="text-align: center;"><b>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</b></p>
1 226	3510.5(c) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure effective infection control procedures were implemented, for one of three residents included in the sample. (Resident #1)  The finding includes:  Observations on September 29, 2011, at approximately 4:38 p.m., Staff #1 picked up Resident #1's newspaper off the floor. A few minutes later, Staff #1 placed her hands inside a box and gave them to the resident without washing her hands. At 5:10 p.m., interview with Staff #1 confirmed that she did not wash her	1 226	

Health Regulation & Licensing Administration

*Erney Stohr*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*President*

(X6) DATE  
*10/24/11*

Health Regulation & Licensing Administration

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I 226	Continued From page 1  hands prior to serving Resident #1 his snack. Further interview revealed that she had received training on infection control procedures.  Review of the in service training records on September 30, 2011, at approximately 3:00 p.m., revealed that all staff had received training on infection control on September 14, 2011. At the time of the survey, there was no evidence, however, that the training to prevent infectious diseases had been effective.	I 226		
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS  Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners.  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure that outside services meet the needs of each resident, for three of three residents in the sample (Residents #1, #2, and #3).  The findings include:  1. On September 29, 2011, at 4:35 p.m., evening observations revealed Resident #1 sitting in a chair in his bedroom with both feet elevated holding a newspaper. Further observations revealed the resident wearing ted stockings that stop just below the knee. At 4:52 p.m. and 5:56 p.m., Resident #1 was observed sitting in his room watching television with both legs elevated. After dinner at 6:50 p.m., the resident's feet	I 405	The Day Program was contacted by the Q.I.D.P on 10/03/11 regarding resident #1's feet elevation program. The day program assured the Q.I.D.P that they will follow the medical orders. The Q.I.D.P visited the Day Program on 10/18/11 and the Day Program staff was retrained 10-18-11 on individual's feet elevation protocol with emphasis on the exceptions during meal time and for activities lasting not more than 15 minutes. The Q.I.D.P will make weekly visits to day program for one month and follow up with monthly visits to ensure that the Day Program staff are implementing the protocol on a consistent basis.  (See Attachment "B")	10/03/11 & 10-18-11

Health Regulation & Licensing Administration

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I 405	Continued From page 2  remained elevated while sitting. Interview with Staff #1 on the same day at 6:52 p.m. revealed Resident #1's feet were to remain elevated while sitting due to his edema.  On September 29, 2011, at 1:07 p.m., observations conducted at the day program revealed Resident #1 sitting in his classroom looking through a newspaper with both legs placed on the floor. Continued observations from 1:08 p.m. to 1:38 p.m. revealed the resident remained seated in a chair with his feet on the floor. During this time, the resident alternated between playing the guitar and turning the pages of his newspaper.  On September 30, 2011, at 10:23 a.m., review of the medical records revealed physician's orders (POS) dated September 2011. The POS revealed the resident had a diagnosis of Intermittent Pedal Edema. Further review of the POs revealed to keep Resident #1's legs elevated while seated during the day time.  Interview with the qualified intellectual disabilities professional (QIDP) on September 30, 2011, at 1:39 p.m. and 1:54 p.m. respectively revealed that the GHPID provided the day program with a foot stool to ensure his feet were elevated. Further interview revealed that the day program had a copy of the current physician's orders and a copy of the foot stool protocol dated January 1, 2011.  At the time of the survey, the day program failed to ensure that Residents #1's feet were elevated during the day as prescribed.  2. On September 29, 2011, at beginning at 6:04 p.m., Resident #3 was observed calmly seated in	I 405	2. The Q.I.D.P contacted the day program staff on 10/03/11 regarding resident # 3's feet elevation program. The day program assured to follow the medical protocol. The QIDP visited the day program on 10/19/11 and day program staff was retrained on	10/19/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 14TH STREET, SE WASHINGTON, DC 20003</b>	
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I 405	Continued From page 3  the sitting room on the couch with her feet elevated. The resident remained with her feet elevated until 6:28 p.m., when she was escorted back upstairs by a staff. Observation of Resident #3 at her day program on September 29, 2011, from 2:05 p.m. to 2:42 p.m., however, revealed the resident's feet were resting flat on the floor, as she sat in the multipurpose room watching a music video with her peers.  Interview with medication administration nurse on September 29, 2011, at 6:25 p.m., revealed Resident #3 had an order to have her feet elevated while sitting and to wear Ted stockings, to prevent leg edema.  On September 30, 2011, at 12:17 p.m., review of Resident #3's physician's orders (POS) dated September 2011, revealed treatment orders to "keep both legs elevated while seated" and for "Ted Hose on both legs as directed."  Interview with the QIDP on September 30, 2011, at 1:54 p.m., revealed that the GHPID provided the day program with a foot stool to ensure Resident #3's feet were elevated when she was seated.  At the time of the survey, however, the day program failed to ensure that Residents#3's feet were elevated when seated as prescribed.	I 405	10/19/11 on the individual's feet elevation protocol with emphasis on the exceptions during meal time and activities lasting not more than 15 minutes. The Q.I.D.P will make weekly visits to the Day Program for one month and follow up with monthly visits to ensure that the day program staff are implementing the protocol on a consistent basis.  (See Attachment "C")
	3. Observations conducted at the day program on September 29, 2011, from 1:48 p.m. to 2:15 p.m., revealed Resident #2 was sitting in his wheelchair in front of his classroom table. The resident was engaging in conversations with his teacher and his classmate. At 1:57 p.m., Resident #2 ate his snack as he sat in his wheelchair. At 4:53 p.m., the resident was	3.	The Q.I.D.P spoke to the day program coordinator on 10/03/11 in reference to resident #2's transfer and mobility protocol as per the training by DCHC P.T and Q.I.D.P on 03/08/11. 10-03-11

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I 405	<p>Continued From page 4</p> <p>observed to use his walker while walking to the dining table with the support of staff. The resident was observed seated in a chair at the table as he ate his snack. At 6:31 p.m., the resident was observed at the table in a chair eating dinner. Resident #2 was not observed to use his wheelchair once he arrived home from the day program.</p> <p>On September 30, 2011, at 9:45 a.m., review of the physical therapy meeting summary note dated March 2, 2011, indicated that while at the day program, Resident #2 should be transferred from the wheelchair to a regular chair while in the classroom or dining area. Further review revealed the resident's wheelchair should only be used for long distances.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 30, 2011, at approximately 10:00 a.m., revealed the physical therapist and the QIDP trained the day program staff on the use of Resident #2's wheelchair on March 8, 2011.</p> <p>At the time of the survey, the day program failed to ensure that Resident #2 sat in a regular chair as recommended by the physical therapist.</p> <p>4. On September 29, 2011, at 1:48 p.m., Resident #2 was observed engaging in conversations with his teacher and his classmate. At 1:57 p.m., the day program staff opened a bag of crackers and handed the crackers to Resident #2. The resident then began to eat his crackers without washing or sanitizing his hands. Interview with the house manager on September 30, 2011, revealed that the day program should have had Resident #2 wash his hands before he consumed his food.</p>	I 405	<p>The Day Program staff was retrained on 10-20-11 on:</p> <ul style="list-style-type: none"> <li>a. Transfer and mobility protocol from wheelchair to regular chairs.</li> <li>b. Use of rolling walker by individual for short distances.</li> <li>c. Use of wheelchair for long distances.</li> </ul> <p>The Q.I.D.P will visit the day program weekly for two weeks and then monthly for two months and continue quarterly visits.</p> <p>(See attachment "D")</p> <p>4. The deficiency was shared with the Day Program on 10/03/11 for implementation of infection control procedures and continue ongoing training. The Day Program staff was trained on 10-20-11 on health care associated infections and the importance of hand washing at all times especially when handling food.</p>

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I 405	Continued From page 5  There was no evidence that proper infection control procedures were implemented at the day program.	I 405	The Q.I.D.P will make weekly visits to the day program for two months and then monthly to ensure that the physicians order and protocols for all individuals are implemented consistently.  (See attachment "D")
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