Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942986	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSE'S HELPING . . ALF INC.	7191 71ST STREET NORTH PINELLAS PARK, FL 33781

(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) COMPLETE DATE
A 000	Initial Comments A complaint survey (complaint #2023006234) was conducted at Nurses Helping . . . ALF Inc. on . Deficiencies were identified at the time of survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a . . . -to- . . . medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a . . . may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to determine the appropriateness of a resident (Resident #1) for admission to the facility, and their ability to meet the resident's needs. After Resident #1 eloped, the facility failed to assess the resident's appropriateness to continue living in the facility. The facility retained Resident #1 in the facility, but failed to ensure safety measures were in place to prevent future elopements. Findings Included: An interview was conducted with Staff A on at 9:32am. In the interview, she stated that they had a resident from the facility, it was Resident #1. Resident #1 was new to the facility and was very and seemed to be getting more . . . . . At night, her . . . . . became worse. Resident #1 went out a door and started walking up the street. She . and was taken to the hospital. The staff had to redirect her on a regular basis because she did not understand where she was. The facility made no changes that would protect Resident #1, after the elopement, because the facility was not a memory care facility, and they could not supervise any one resident all of the time. An observation and interview were conducted with Resident #1 on . . . . . at 9:55am. She was seated at a table in the dining room and stated her first and last name. She stated she did not know where she was, but thought she was in another city, in another state. She stated that she did not live in the facility. She stated she had meals there, but did not know where she slept. She stated she had no idea what day it was.	A 010		

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A 010	Continued From page 5 An interview was conducted with Staff B on . . . . . at 11:25am. In the interview, she stated that the prior evening (on), Resident #1 got outside the facility again, it was sometime around 8:00pm. This was the 2nd time, she was aware of, that Resident #1 got outside of the facility without any of the staff knowing. She had seen the resident earlier, after dinner, and she acted as though she was tired, so she helped her get ready for bed, into her night clothes. Then later, she was helping other residents get ready for bed, and she saw Resident #1 with her jacket on over her night clothes. The resident said it was because she was . . . . Staff B said she didn't think that much of it, that Resident #1 had put a jacket on, but then she walked by the front door and saw it was ajar. She looked outside and didn't see anyone. She went . . . and checked Resident #1's room and could not find her. She alerted everyone working in the facility that night, and they searched inside the building and could not find Resident #1. The Administrator and Assistant Administrator were notified about the missing resident and started driving around trying to find her. She was found about 20 minutes later, in a residential neighborhood down the street from the facility. She stated they do not have anyone, like a receptionist, who sits near the front door, making sure that residents leaving the facility are authorized to go. An interview was conducted with the Assistant Administrator at 11:50am on . In the interview, she stated that Resident #1 was new to the facility and this was the 2nd time she got out, unnoticed. She said the family was very happy with the facility, more than the last place where she wasn't receiving enough care. She stated that this was not a memory care facility and she	A 010		

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A 010	Continued From page 6	A 010		

did not believe that Resident #1 was an elopement risk. She hoped that they could keep the resident at this facility because her family seemed so happy about them. She stated she felt that they could keep the resident safe. She stated that when Resident #1 came to the facility, her healthcare provider did not consider her to be an elopement risk. She stated that after the last time the resident eloped, her family brought her an identification bracelet to wear in case she went missing. They also got her some kind of device that was supposed to alert someone if something was wrong, but she was not wearing it last night (when the 2nd elopement occurred).

A review of Resident #1's record was conducted on . . . . The review revealed an AHCA 1823 assessment dated , with no stated medical history or diagnoses, only a note to "see record". There was a notation that the resident's . . . . . or behavioral status was "MMSE . . . . . " (a mini-mental state examination, with a score of 12 out of 30, which translates to moderate . . ,). The section for elopement risk was marked "no", but the section for . risk was marked "yes". Another AHCA 1823 assessment, in the record, was dated . . . . . It contained a medical history and diagnoses of . . . . . and . . . . . It stated the resident's . . status was " " and stated there were no special precautions and that the resident was not an elopement risk. At the time of the review, these were the only assessments in Resident #1's record that were valid for the period of time that she lived in the facility, prior to the latest elopement on . Another AHCA 1823 assessment was dated . . . . . , and was added to the record after the Assistant Administrator notified the resident's healthcare provider about the 2nd elopement, that occurred on , the

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A 010	Continued From page 7	A 010		

previous evening. The newest AHCA 1823 assessment, dated , noted that Resident #1 was an elopement risk. Resident #1's record also revealed a resident observation log, that included an entry on . . . . . The entry stated that during the 3 - 11 shift, the staff went to the resident's room to get her roommate and noticed she wasn't there. They started looking for her, and then when the staff couldn't find her, they notified the administrator. The administrator got in her car and started driving around looking for her, and could not find her. Around 1:00pm, the administrator called the police to notify them about the missing resident. Between 1:00 - 2:00pm, the resident's family member called and said she was at the hospital with the missing resident and that she had been notified by the police about the resident's whereabouts.

An interview was conducted with the Administrator at 2:10pm on . . . . . In the interview, she stated that the facility had no working cameras inside or outside the facility. She stated that there were 8 doors that allowed access in and out the facility, and none of them were locked, except at night when there were no visitors in the facility. There were no set times when doors were locked, due to residents that wanted to go outside and smoke, and for visitors who wanted to come in and or go out. There were 4 doors that had alarms set up on them, but the residents, in rooms nearby, would turn them off because of the noise. They did not have a receptionist, or anyone who watched the front door, to see who was coming in or going out of the facility. There was an outside patio, that they thought Resident #1 walked out of, when eloping on . It was not locked and opened onto a large yard with a parking lot. There was a wooden fence around the facility, but it was completely

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A 010	Continued From page 8 opened on one side, where the driveway was, and the driveway led to the main road. The 2nd elopement (the previous evening) Resident #1 walked out the front door, unnoticed, around 8:00pm. She walked down the sidewalk to a neighborhood south of the facility. She and the Assistant Administrator drove around to find her and noticed an ambulance in the neighborhood, where they found her being assisted by the emergency management technicians. Photographic evidence obtained. Class III	A 010		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at	A 032		

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A 032	Continued From page 9 risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.	A 032		

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A 032	Continued From page 10 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate supervision and maintain a general awareness of the resident's whereabouts to a resident known to be . . . . . with previous elopement history. Furthermore, the facility failed to maintain a written record, updated as needed, of any significant changes that resulted in the provision of additional services for 1 resident of 1 (Resident #1), whose records were reviewed. The facility's lack of supervision and lack of implementation of preventative measures directly threatened the safety and security of Resident #1. Findings Included: A review of a facility reported incident on . . . . , that was filed by the facility with regards to Resident #1's elopement from the facility on , revealed that around 11:00am to 11:30am that day, the resident was found by the road. That last time any of the facility staff remembered seeing her was around 10:00am when she was seen in the dining room. At 10:45am the staff noticed she was nowhere to be found and started looking through the facility, room to room. The Administrator started driving around looking for her and also called the police. At 11:15 the Assistant Administrator called Resident #1's family member and learned that the family member was at the hospital with Resident #1. The resident was later returned to the facility. The analysis of the situation, as reported by the facility, was that the resident followed another resident outside through an unlocked door, and from there onto the sidewalk and began walking down the street. Someone driving by saw her, on the sidewalk, and called an	A 032		

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ambulance. The facility reported that their corrective action plan, to prevent Resident #1 from eloping again, was to place signs for residents and staff, who smoke outside the building, not to leave doors open, and to place signs for Resident #1 to find her room. Also, that the family was purchasing an identification bracelet for the resident to wear and they were considering purchasing a tracking system for her, in case she outside of the facility again.

An interview was conducted with Staff A on at 9:32am. In the interview, she stated that Resident #1 had from the facility. Resident #1 was very . . . . , and seemed to be getting more and more . At night, her became worse. Resident #1 went out a door and started walking up the street (a 4 lane divided major road). She was seen by a passerby, and was taken to the hospital. Staff A stated that, after Resident #1 was returned to the facility, they made no changes that would protect Resident #1, after the elopement, because the facility was not a memory care facility and they could not supervise any one resident all of the time.

An observation and interview were conducted with Resident #1 on at 9:55am. She was seated at a table in the dining room and stated her first and last name. She stated she did not know where she was, but thought she was in another city, in another state. She stated that she did not live in the facility. She stated she had meals there, but did not know where she slept. She stated she had no idea what day it was.

An interview was conducted with Staff B on at 11:25am. In the interview, she stated that the prior evening (on), Resident #1 got

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outside the facility again, it was sometime around 8:00pm. This was the 2nd time, she was aware of, that Resident #1 got outside of the facility without any of the staff knowing. She had seen the resident earlier, after dinner, and she acted as though she was tired, so she helped her get ready for bed, into her night clothes. Then, later, she was helping other residents get ready for bed, and she saw Resident #1 with her jacket on over her night clothes. The resident said it was because she was . . . . Staff B said she didn't think that much of it, that Resident #1 had put a jacket on, but then she walked by the front door and saw it was ajar. She looked outside and didn't see anyone. She went . . . and checked Resident #1's room and could not find her. She alerted everyone working in the facility that night, and they searched inside the building and could not find Resident #1. The Administrator and Assistant Administrator were notified about the missing resident and started driving around trying to find her. She was found, about 20 minutes later, in a residential neighborhood down the street from the facility. She stated they do not have anyone, like a receptionist, who sits near the front door, making sure that residents leaving the facility are authorized to go.

An interview was conducted with the Assistant Administrator at 11:50am on . In the interview, she stated that Resident #1 was new to the facility and this was the 2nd time she got out, unnoticed. She said the family was very happy with the facility, more than the last place where she wasn't receiving enough care. She stated that this was not a memory care facility and she did not believe that Resident #1 was an elopement risk. She hoped that they could keep the resident at this facility because her family seemed so happy about them. She stated she

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NURSE'S HELPING . . ALF INC.	7191 71ST STREET NORTH PINELLAS PARK, FL 33781

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felt that they could keep the resident safe. She stated that when Resident #1 came to the facility, her healthcare provider did not consider her to be an elopement risk. She stated that after the last time the resident eloped, her family brought her an identification bracelet to wear in case she went missing. They also got her some kind of device that was supposed to alert someone if something was wrong, but she was not wearing it last night (when the 2nd elopement occurred).

A review of Resident #1's record was conducted on . . . . . The review revealed an AHCA 1823 assessment dated , with no stated medical history or diagnoses, only a note to "see record". There was a notation that the resident's or behavioral status was "MMSE " (a mini-mental state examination, with a score of 12 out of 30, which translates to moderate ,). The section for elopement risk was marked "no", but the section for risk was marked "yes". Another AHCA 1823 assessment, in the record, was dated . . . . . It contained a medical history and diagnoses of . . . . . and . . . . . It stated the resident's status was " " and stated there were no special precautions and that the resident was not an elopement risk. At the time of the review, these were the only assessments in Resident #1's record that were valid for the period of time that she lived in the facility, prior to the latest elopement on . Another AHCA 1823 assessment was dated . . . . . , and was added to the record after the Assistant Administrator notified the resident's healthcare provider about the 2nd elopement, that occurred on , the previous evening. The newest 1823, dated , noted that Resident #1 was an elopement risk. Resident #1's record also revealed a resident observation log, that included an entry on

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. . . . . The entry stated that during the 3 - 11 shift, the staff went to the resident's room to get her roommate and noticed she wasn't there. They started looking for her, and then when the staff couldn't find her, they notified the administrator. The administrator got in her car and started driving around looking for her, and could not find her. Around 1:00pm, the administrator called the police to notify them about the missing resident. Between 1:00 - 2:00pm, the resident's family member called and said she was at the hospital with the missing resident and that she had been notified by the police about the resident's whereabouts.

An interview was conducted with the Administrator at 2:10pm on . . . . . . In the interview, she stated that the facility had no working cameras inside or outside the facility. She stated that there were 8 doors that allowed access in and out the facility, and none of them were locked, except at night when there were no visitors in the facility. There were no set times when doors were locked, due to residents that wanted to go outside and smoke, and for visitors who wanted to come in and or go out. There were 4 doors that had alarms set up on them, but the residents, in rooms nearby, would turn them off because of the noise. They did not have a receptionist, or anyone who watched the front door, to see who was coming in or going out of the facility. There was an outside patio, that they thought Resident #1 walked out of, when eloping on . It was not locked and opened onto a large yard with a parking lot. There was a wooden fence around the facility, but it was completely opened on one side, where the driveway was, and the driveway led to the main road. The 2nd elopement (the previous evening) Resident #1 walked out the front door, unnoticed, around

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A 032	Continued From page 15 8:00pm. She walked down the sidewalk to a neighborhood south of the facility. She and the Assistant Administrator drove around to find her and noticed an ambulance in the neighborhood, where they found her being assisted by the emergency management technicians. A tour of the facility was conducted at 2:10pm on . . . . . The front door was observed to be unmanned, without a receptionist. There were 2 corridors containing resident rooms, and on each end of each corridor, there were unlocked exit doors. All 4 exit doors had alarms attached, that would go off if someone opened the doors, however one door alarm was observed not to be functioning - when the door was opened, no alarm sounded. The front door was also observed to be unlocked, and did not contain an alarm, all one had to do was to push on the door and it opened. Photographic evidence obtained. Class II	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee	A 081		

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completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).
(b) New staff must complete the preservice orientation prior to interacting with residents.
(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.
(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents,

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other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training.
(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:
1. Resident behavior and needs.
2. Providing assistance with the activities of daily

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A 081	Continued From page 18 living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all facility staff received in-service training regarding the facility's resident elopement response policies and procedures, within thirty (30) days of employment, for 1 of 3 staff members (Staff C), whose records were reviewed. Findings included: A review of Staff C's record was conducted on . The record revealed that Staff C had been working in the facility since . There was no evidence, in the record, that Staff C had any in-service training on the facility's elopement response policies and procedures. In an interview with the Administrator and	A 081		

Agency for Health Care Administration

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A 081	Continued From page 19 Assistant Administrator at 3:00pm on . . . . , neither one of the administrators had any comment to add, or evidence to show that Staff C did have the elopement response training. Class III	A 081		