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D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey and complaint investigation on March 16-18, 2016. The complaint investigation was initiated by the Cabarrus County Department of Social Services on March 11, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #1) regarding refusal of antibiotics and incontinence care resulting in septicemia and death secondary to a newly diagnosed autoimmune disorder. The findings are: A. Review of Resident #1's current FL-2 dated 5/26/15 revealed diagnoses included traumatic brain incident, cerebral trauma, L2-L5 fracture and hemiplegia. Review of Resident #1's Resident Register revealed an admission dated 5/26/15. Review of Resident #1's Personal Care Plan	D 273		

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dated 5/27/15 revealed:
-Resident #1 was "Totally Dependent" upon staff for toileting, bathing, grooming/personal hygiene, and dressing.
-Resident #1 required extensive assistance for transfer/mobility.

Review of the August 2015 Personal Care Log revealed:
-Resident #1 refused all assistance offered related to bathing, personal hygiene, toileting, dressing, shampoos, locomotion, medication and transfers from 8/01/15 to 8/31/15.
-Staff initialed each task and circled their initials indicating that the resident refused.

Review of the September 2015 Personal Care Log revealed:
-Resident #1 refused all assistance offered related to bathing, personal hygiene, toileting, dressing, shampoos, locomotion, medication and transfers from 9/01/15 to 9/30/15.
-Staff initialed each task and circled their initials indicating that the resident refused.

Review of Resident #1's Progress Notes revealed:
-On 5/26/15 Resident #1 was admitted, her guardian signed all paperwork and she looks well and alert.
-In the month of June it was documented that she refused medications on six occasions.
-She refused showers on at least 10 occasions despite multiple attempts.
-She refused changing of her undergarment and pericare on at least 6 documented occasions that included multiple shifts, despite multiple attempts.
-She refused 4 meals.
-On 6/07/15 Resident #1 "had 3 bowel movements and had open areas in her perineal

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region which were blister like which burned, itched and hurt".
-There was no documentation that the physician was notified of the condition of Resident #1's perineal area.
-On 6/13/15 Staff documented that Resident #1's "peri-area broken skin and a rash that needed a doctor's attention".
-There was no documentation that staff notified Resident #1's physician of the noted rash.
-On 6/17/15 Staff contacted Guardian and reported non-compliant with staff's attempts to provide hygiene care.
-On 6/21/15 Resident #1 refused to let staff assist her with pericare, undergarment changes and her peri-region was still red and excoriated.
-On 6/25/15 the Resident #1 refused 8:00 am medications. She also refused to shower despite encouragement from the Administrator. The Administrator notified the Guardian of the refusal and the Guardian brought Resident #1 lunch, Resident #1 allowed PCA to change her and promised to shower later. After the Guardian left the facility Resident #1 refused to shower.
-On 6/26/15 Staff and the Administrator encouraged Resident #1 to take a shower and staff documented, "Staff has pretty much done all they could for her."
-In the month of July it was documented that she refused medications on 9 occasions.
-She refused showers on at least 6 occasions despite multiple attempts.
-She refused changing of her undergarment and pericare on at least 9 documented occasions that included multiple shifts, despite multiple attempts.
-She refused 9 meals.
-On 7/02/15 Resident #1 requested to be sent to the hospital because her peri-area was hurting. Staff called 911 and once the ambulance arrived Resident #1 requested to smoke a cigarette and

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the EMS team denied the request and she then refused their services. The Guardian and the Administrator were notified.
-There was no documentation that Resident #1's physician was notified of this incident.
-On 7/05/15 Resident did not get out of bed because of pain in her peri-area and she refused breakfast, lunch and her 8:00 pm medications.
-There was no documentation that Resident #1's physician was notified.
-On 7/23/15 Resident #1 "has a large, swollen, infected area with a sore in the center of right buttocks and it is hot to touch" and staff notified the physician and obtained an order for antibiotic.
-On 7/25/15 Resident #1's relative called an ambulance so Resident #1 could be seen by a physician but Resident #1 refused to be transported.
-There was no documentation that Resident #1's physician was notified of this incident.
-In the month of August it was documented that she refused medications on 9 occasions.
-She refused showers on at least 4 occasions despite multiple attempts.
-She refused changing of her undergarment and pericare on at least 16 documented occasions that included multiple shifts, despite multiple attempts.
-She refused 1 meal.

Review of Psychiatry Treatment Plan dated 7/20/15 revealed an order to increase Cymbalta from 60mg to 90 mg everyday (a medication used to treat depression).

Continued Review of Resident #1's progress notes revealed:
-On 8/20/15 Resident #1 refused to be changed all day and her 2:00 pm medications. At 9:15 pm Resident #1 had a temperature of 102.8, she was

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administered acetaminophen (APAP) and temperature decreased to 101.9. She continued to refuse to be changed.
-There was no documentation that Resident #1's physician was notified of Resident #1's temperature.
-On 8/22/15 Resident #1 refused to be changed until 12:15 am and she agreed and vaginal bleeding was documented.
-There was no documentation that Resident #1's physician was notified of the bleeding.
-On 8/22/15 Resident #1 had a temperature of 100.7 at 5:30 am. She refused medication and staff assistance. At 11:40 pm she had a temperature of 102.2 and administered APAP.
-There was no documentation that Resident #1's physician was notified of Resident #1's temperature.
-On 8/23/15 Follow-up temperature decreased to 101.5 and resident continued to refused to be cleaned or changed.
-There was no documentation that Resident #1's physician was notified of Resident #1's temperature.
-On 8/23/15 Resident #1 refused morning and afternoon medications and reported to staff she "has been taking meds for long enough and is tired of taking medication". She refused to get out of bed.
-On 8/23/15 Resident #1 had a temperature of 102.6 and refused APAP and follow-up temperature was 103.1.
-There was no documentation that Resident #1's physician was notified of Resident #1's temperature.
-On 8/24/15 Resident #1 had a temperature of 102.9 and she refused APAP and "medical treatment". Resident #1 continued to refuse to be changed and she had blood on her from scratching but refused to be cleaned.

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D 273	Continued From page 5 -There was no documentation that Resident #1's physician was notified of Resident #1's temperature. -On 8/25/15 Resident refused all care and refused to have temperature taken. Resident Care Coordinator (RCC) called the Guardian and the Guardian instructed the RCC to call the psychiatrist and the RCC left a message for the psychiatrist. -On 8/25/15 The Administrator called the Guardian and informed her that Resident #1 had "a serious medical issue that needed to be addressed but the resident refused." The Administrator informed the Guardian that if Resident #1 "continued to refuse care, she would be discharged because we can't meet her needs. "The Guardian was not in agreement with changing Resident #1's level of care. -On 8/25/15 at 4:50 pm the Administrator spoke with the magistrate about involuntary commitment (IVC) and the magistrate denied this request. Resident #1's family member was called and was willing to transport Resident #1 to the hospital. At 8:50 pm EMS (Emergency Medical Services) was called and transported Resident #1 to the hospital. Messages were left for Resident #1's Guardian. -On 8/29/15 Staff spoke with a representative at the hospital and it was reported that Resident #1 continued to refuse care and medication. -On 9/01/15 Resident #1 returned to the facility. -In the month of September it was documented that she refused medications on 10 occasions. -She refused showers on at least 2 occasions despite multiple attempts. -She refused changing of her undergarment and pericare on at least 4 documented occasions that included multiple shifts, despite multiple attempts. -She refused 6 meals.	D 273		

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D 273	Continued From page 6 Interview with a Personal Care Aide (PCA) on 3/17/15 at 1:00 pm revealed: -After her birthday on August 19, 2015 she "just gave up". -Anything the PCA gave her to eat or drink Resident #1 would refuse. -The protocol at the facility was that if residents were coherent enough then they were able to make their own decisions. -The PCA was concerned that due to Resident #1's decline and depression she was not able to make good decisions. -Resident #1's family member would try to get the Guardian to send Resident #1 to the hospital and the Guardian would not allow it. -Resident #1 had an infant child that died and after her birthday on August 19, 2015 she told the PCA she wanted to go be with her baby. -The staff tried to get Resident #1 to go to the hospital but she refused and EMS could not force her to go. Interview with a former MA on 3/18/15 at 11:30 am revealed: -On Resident #1's birthday, August 19, 2015, some of her family came to visit and after that she would not eat or drink much of anything. -She would refuse to go to the hospital. -She did have blisters on her bottom that eventually burst and her skin was raw. -Resident #1 did have strong smelling urine but the MA did not recall hematuria. -Resident #1 thought she could refuse medical care, but it was really up to the Guardian and the Guardian was "very hard to reach". -When Resident #1 refused medication the MA would call or fax the medical director, but she did not report refusal of care. -She dated these faxes and placed them in an "order file book" and at the end of the month the	D 273		

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Resident Care Director and the Administrator would file them in the resident records.
-Facility staff did everything they could do for Resident #1.

Review of the Psychiatric Physician Treatment Plan dated 9/14/15 revealed:
-The Psychiatric Nurse Practitioner did visit Resident #1 on 9/14/15.
-There were no reports of significant changes in appetite, energy level, sleep or non-adherence to treatment.
-Staff reported to the Nurse Practitioner Resident #1 was better at taking her medications.
-Resident #1 had a history of refusing Activity of Daily Life (ADL) care and refusal of medical care.
-Staff was expected to monitor and report changes in mood/behavioral and medication side effects.
-A statement that the provider "would return on the usual interval unless crisis or emergency occurs and for staff to monitor mood and behavior and report concerns to this provider."

Continued review of Resident #1's Progress Notes revealed:
-On 9/18/15 Resident #1 tried to take all of her 8:00 pm medications but spit them back into the cup stating she, "just couldn't take them".
-On 9/27/15 Resident #1 was throwing up on the back porch. She refused as needed medication and refused to go to the hospital.
-There was no documentation that Resident #1's physician was notified of Resident #1's vomiting.
-On 9/28/15 Resident #1 continued to throw up all night and refused all medications, hydration and to go to the hospital. She was bleeding from her vaginal region but continued to refuse care.
-There was no documentation that Resident #1's physician was notified of Resident #1's vomiting

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or bleeding.
-On 9/29/15 Resident #1 was up once to go smoke but otherwise stayed in bed all day. On third shift, she complained of burning and pain upon urination. She was still bleeding from her vaginal area.
-There was no documentation that Resident #1's physician was notified of Resident #1's vomiting, pain and burning with urination or bleeding.
-On 10/01/15 Resident #1 was throwing up and had a temperature of 100.6, pulse was 100, oxygen saturation was 86%. Resident requested to go to the hospital but when EMS arrived she refused to go to the hospital. Guardian and Administrator notified.
-There was no documentation that Resident #1's physician was notified of Resident #1's temperature, fast pulse or low oxygen saturation.
-On 10/01/15 3:15 pm Resident #1 was transported via EMS to the hospital and returned on 10/02/15.
-On 10/03/15 Resident #1 began throwing up and refused medications and hydration.
-There was no documentation that Resident #1's physician was notified of Resident #1's vomiting.
-On 10/04/15 Resident #1 tried to take her morning medications but threw them all up.
-There was no documentation that Resident #1's physician was notified of Resident #1's vomiting.
-On 10/06/15 Resident #1 did not get out of bed all day. (She did take her medication but did not eat anything.)
-On 10/06/15 Resident #1 "is in hospital."

Review of Resident #1's Discharge Summary from a hospitalization from 8/25/15 to 9/01/15 revealed:
-Resident #1 was admitted and treated for a urinary tract infection (UTI).
-She was discharged with a prescription for a

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sulfamethoxazole-trimethoprim 800mg 1 tablet every 12 hours (an antibiotic used to treat the UTI).
-She was discharged with a prescription for valacyclovir 500mg 2 tablets every 12 hours (an antiviral medication used to manage herpes).

Review of the August 1 through August 25, 2015 Medication Administration Record (MAR) revealed:
-An entry for Cymbalta 30mg and 60mg (total 90 mg) to be administered at 8:00 am everyday and documented as refused 9 out of 25 opportunities.
-The refusals were denoted by the Medication Aide (MA) who documented on the back of the MAR the refusal, and circled their initials on the front of the MAR as not administered.
-Refusal dates included 8:00 am on 8/08, 8/09, 8/11, 8/12, 8/14, 8/17, 8/22, 8/23, and 8/25/15.

Review of the September 2015 MAR revealed:
-An entry for sulfamethoxazole-trimethoprim 800mg 1 tablet every 12 hours at 8:00 am and 8:00 pm and documented as refused for 12 of 23 opportunities.
-The refusal dates included the 8:00 am dose on 9/02, 9/05 and 9/07 and the 8:00 pm dose on 9/01, 9/02, 9/04, 9/05, 9/06, 9/07, 9/09, 9/10 and 9/12/15.
-The refusals were denoted by the MA who documented on the back of the MAR the refusal, and circled their initials on the front of the MAR as not administered.
-An entry for valacyclovir 500mg 2 tablets every twelve hours at 8:00 am and 8:00pm and documented as refused for 19 of 45 opportunities.
-The refusals were denoted by the MA who documented on the back of the MAR the refusal, and circled their initials on the front of the MAR as

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not administered.
-Refusal dates included the 8:00 am dose on 9/02, 9/05, 9/07, 9/19 and 9/20, and the evening dose every night from 9/04 to 9/16/15 except for 9/08/15.
-An entry for Cymbalta 30mg and 60mg (total 90 mg) to be administered at 8:00 am everyday and documented as refused 6/30 opportunities.
-The refusals were denoted by the MA who documented on the back of the MAR the refusal, and circled their initials on the front of the MAR as not administered.
-Refusal dates included the 8:00 am dose on 9/02, 9/04, 9/05, 9/07, 9/19 and 9/20/15.

Review of Resident #1's Record Revealed:
-Documentation of EMS Refusals of transport on 7/02/15, 7/25/15 and 10/01/15.
-A fax dated 9/13/15 with documentation Resident #1 was "refusing night med's but not on a daily basis" and signed by Resident #1's primary care physician.

Review of the Facility's Policy on Refusals revealed:
-It was the policy of the facility that any resident that refuses medication three consecutive times, the facility will inform the medical director.
-Any resident that refused care for "at least" three days, the medical director would be notified.
-If the resident refused to seek medical attention by 911 the guardian, Power-of-Attorney or Responsible Party would be notified immediately, this could possibly be grounds for discharge.

Interview with the Administrator on 3/16/16 at 1:30 pm revealed:
-She talked to Resident #1 over and over and told Resident #1 she needed to allow staff to help her or she would be discharged.

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D 273	Continued From page 11 -Resident #1 would be compliant for 2 or 3 days and then "revert back to her old behavior". -Resident #1 and her family member wanted to be roommates and in efforts to facilitate this they wanted to keep them together. -Resident #1 did not improve compliance after her family member moved in. -The Administrator contacted the Guardian on multiple occasions and the Guardian was difficult to reach and would also refuse to send Resident #1 to the hospital stating, "[Resident #1] had a right to refuse the hospital". -She never initiated a discharge with Resident #1's Guardian, but did discuss this on several occasions. -She did discuss the refusals of care and medications with the physician but did not know when or how often. -She kept her own documentation and thought she had faxes that could reflect when she notified the physician. -The documentation and the faxes were not located during the survey. A second interview with the Administrator on 3/17/15 at 3:40 pm and 4:05 pm revealed: -The Administrator did not pursue the discharge because the Administrator wanted to support Resident #1's wishes to live with her family member. -The Administrator thought about discharging Resident #1 when she was hospitalized in late August but did not initiate discharge procedures. -Staff were offering care but were unable to provide the care Resident #1 required due to the refusals. -If it was not for trying to keep Resident #1 and her family member together, the Administrator would not have re-admitted Resident #1 on 9/01/15.	D 273		

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D 273	Continued From page 12 -The Administrator did discuss refusals of medication and care with Resident #1's primary care physician. -The physician recommended the staff encourage her and utilize family members to encourage her but recognized that Resident #1 had the right to refuse treatment and medications. -The Primary Care Physician made quarterly visits. -She did not report refusals to eat, drink and stay in bed to the in-house psychiatric physician because the Adminsitrator had not thought to utilize this service for emergencies in the past. -The Administrator did try to have an IVC initiated to have Resident #1 hospitalized, but the magistrate would not grant one. -The Administrator contacted the Guardian several times to discuss hospitalization and alternative care settings, but the Guardian refused each time. -The Administrator was not aware of Resident #1's diagnosis of acquired immunodeficiency syndrome until Resident #1's last hospitalization. Interview with a second former MA on 3/18/15 at 12:20 pm revealed: -When Resident #1 first moved to the facility, she was pleasant but in August she became a recluse and began refusing to get out of bed. -Resident #1 had sores on her perineal area she would scratch and would bleed and "eventually looked like chopped up hamburger meat." -"We would try to bribe her with cigarettes" just to get her up to change her and her family member "would help us to convince her". She still refused care. -Resident #1's urine was strong smelling but never had blood present. -The MA informed Resident #1's physician about her temperatures and then would have to call the	D 273		

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	HAL013042	A. BUILDING: _____ B. WING _____	03/18/2016

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D 273	Continued From page 13 Guardian for permission to send Resident #1 to the hospital. -The MA did not report refusal of care to the physician. -The MA attempted to report the refusals to the Guardian and the Guardian would not answer the phone or come to visit Resident #1. -The MA called the Guardian for permission to send to the hospital and the Guardian wanted Resident #1 to stay at the facility. Interview with a second PCA on 3/18/15 at 1:20 pm revealed: -Resident #1 had told her about her history of abuse and a very serious automobile accident. -Resident #1 was happy but then became depressed and told the PCA she was tired of living. -The skin on Resident #1's bottom was scalded from a constant infection that they tried to treat but never seemed to go away. -PCA had to "coax" Resident #1 to let the PCA provide care. -Resident #1 refused to eat and only ate when her family brought in food for her. -Resident #1's urine had a strong odor but was never bloody. -The PCA did not report refusal of care to the physician because this was the responsibility of the MA and/or Administrator. -The PCA reported the refusals to the supervisor. Interview with a third PCA on 3/18/15 at 1:30 pm revealed: -Resident #1 did not have bed sores or irritation when she first came to the facility. -Over time her skin deteriorated like a "very bad diaper rash". -Resident #1's urine had a strong odor but was not bloody.	D 273		

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D 273	Continued From page 14 -She was present on several occasions when staff or Resident #1's family tried to contact the Guardian. Interview with Resident #1's Guardian on 3/17/15 at 8:11 am revealed: -She generally would visit her clients quarterly or as needed. -She did expect the facility to inform her if there was a change in Resident #1's status or condition that may warrant her to visit. -Staff reported to the Guardian about some of Resident #1's refusals to go to the hospital only after the EMS had already left. -Resident #1 refused to go to the hospital on 7/02/15 and 7/25/15 and the Guardian did not find out about these refusals until the Guardian visited Resident #1 at the facility on 7/28/15. -The last time Resident #1 went to the hospital the facility staff called "me because the EMS did not want to transport Resident #1 due to her refusal". After speaking with the EMS supervisor they transported her to the hospital without incident. -On 6/17/15 the Administrator reported to the Guardian that Resident #1 was refusing care and medications. -On 6/22/15 staff reported to the Guardian that Resident #1 was compliant and there were no other calls about Resident #1 refusing care, refusing meals or being depressed. -On 8/20/15 the Guardian received a message from [named staff member] that Resident #1 was refusing care. -On 8/25/15 the staff called and reported to the Guardian Resident #1 had a change in status and would not get out of bed, was refusing care and medications. At this time "I requested a psychiatric consult and this was refused because the psychiatrist would not be at the facility until	D 273		

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D 273	Continued From page 15 the next week". -Resident #1 went to the hospital on 8/25/15 and was treated for a urinary tract infection. Resident #1 continued to be non-compliant in the hospital. -On 9/03/15 at 7:00 pm staff left a message informing the Guardian about Resident #1 being non-compliant with medications and care. -The Administrator only talked about alternative care placement during the crisis moments when they were trying to send her to the hospital on 8/25/15 and 10/01/15. -The Guardian did refuse the notion of discharge on 10/01/15 because she felt they were threatening discharge based on non-compliance and not medical necessity. -The Guardian and the Administrator or Resident Care Director never had a care meeting to discuss re-scheduling bath times or medication times to increase compliance or to upgrade Resident #1's level of care. -The Guardian called the facility on 10/05/15 to follow-up on the 10/01/15 hospital visit and staff reported that Resident #1 was fine and nothing was going on with her. -On 10/06/15 Resident #1 was transported to the hospital and admitted for sepsis secondary to a urinary tract infection. Interview with the Psychiatric Service Medical Director on 3/17/16 at 3:15 pm revealed: -The Psychiatric Physicians and Nurse Practitioners did expect that the staff would report changes in behavior and suicidal ideations. -The Physician was unaware that Resident #1 was deceased. -If the psychiatric service provider was aware of Resident #1's continued non-compliance, mental decline, and physical deterioration, the psychiatric	D 273		

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D 273	Continued From page 16	D 273		

service provider would have called the Guardian and reported the changes as well as encouraged the Guardian to seek alternative placement and medical treatment.

Review of Resident #1's Primary Care Physicians's quarterly Progress note dated 8/14/15 revealed:
-"Patient was being assessed and evaluated for the continued need for long term care."
-"Ongoing issues were care refusal, medication refusal and inappropriate behavior."
-EMS was called on more that one occasion and resident "refused to be transported to the hospital".
-Review of systems were "significant for cough with rhonchi, urinary symptoms, vaginal discharge, decubitus and urinary incontinence".
-The Long Term Plan included "the patient continues to require long term care due to multiple medical issues and ongoing need for skilled nursing care, skin care, nutritional care and medical care".

Interview with Resident #1's Primary Care Physician on 3/17/16 at 2:25 pm revealed:
-He encouraged that staff try to convince Resident #1 to take her medications, call the family and get them involved to encourage her to take her medications but they could not force her to take the medications.
-He was aware of her non-compliance, but did not know how often he was notified.
-He did not manage her psychiatric medications.
-His last visit with Resident #1 was on 8/14/15.

Review of an Inpatient Psychiatric Consult dated 8/27/15 revealed:
-"Mood was depressed, affect blunted. There was no active suicidal ideation, but there was a

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D 273	Continued From page 17 significant sense of hopelessness." -A recommendation to provide supportive care and that the client may "actually benefit from a change of her assisted living and when I suggested that she did smile." -A recommendation to involve palliative care. Review of Resident #1's Physician Progress notes dated 10/06/15 revealed: -Resident #1's urine was red and red blood cells were too numerous to count. -Resident #1 had a stage II decubitus ulcer on coccyx that measured 5.5 centimeters in length and 1.5 cm width. Review of Resident #1's Discharge Summary from hospitalization dated 10/06/15 through 11/05/15 revealed: -Resident #1 was discharged to Hospice on 11/05/15. -The discharge diagnoses included sepsis syndrome, gram negative bacteremia and advanced acquired immunodeficiency syndrome. Review of Resident #1's Hospice Records revealed Resident #1 was admitted to Hospice on 11/05/16 and expired on 11/10/15. _____ A plan of protection was provided by the facility on 3/17/16 as follows: -Effective immediately, the Administrator will review all resident records to make sure the facility can meet all their needs. -The Administrator will discuss all findings with the owner of the facility and the responsible parties if the facility can not meet the residents' needs and will make arrangements for appropriate placement. -If Administrator reviews records and sees that the facility cannot meet residents' needs the	D 273		

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D 273	Continued From page 18 residents will be given a discharge notice at that time. -The refusal policy will be reviewed with each staff member and the Administrator will make sure that the policy is being enforced. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 23, 2016.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding health care referral and follow-up. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #1) regarding refusal of antibiotics and incontinence care resulting in septicemia and death secondary to a newly diagnosed autoimmune disorder. [Refer to Tag 0273, 10A NCAC 13F .0902 (b)(Type B Violation).]	D912		

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