STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

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N 000	Initial Comments On 05/28/2024, Surveyor conducted two complaint investigations at Eagles Rest at Pepin. Data collection continued through 06/11/2024. Both complaints were substantiated. Five deficiencies were identified. Census: 25	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not take immediate steps to ensure the safety of all residents and did not investigate	N 158		

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

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and document Resident 1's allegation of misappropriation of property.

Findings include:

On 05/14/2024, the Department received a complaint regarding resident care.

INTERVIEWS

On 05/28/2024 at approximately 12:30 PM, Surveyor interviewed Resident 1 in his/her room. Resident 1 stated s/he did not want to talk in the building as s/he was not comfortable. Resident 1 instructed Surveyor to reach out to his/her managed care organization (MCO) case manager for all his/her concerns.

On 05/29/2024 at approximately 9:45 AM, Surveyor spoke to Nurse Case Manager (NCM) C via phone. NCM C informed Surveyor that Resident 1 had purchased sweatshirts that were too small and Administrator A stated s/he would take them for him/herself or child, and would replace them with larger ones, approximately one month ago. Last week, Licensee B gave Resident 1 $50 for the sweatshirt/hoodies that Administrator A did not order to replace the sweatshirts s/he had taken from Resident 1.

On 06/07/2024 at 8:10 AM, Surveyor interviewed Licensee B via phone and asked if s/he was made aware Administrator A had taken sweatshirts from Resident 1. Licensee B stated, "Yes, [Resident 1] had a complaint about [Administrator A]. [Resident 1] had ordered sweatshirts that were too small and talked to [Administrator A] who offered to take the small ones and buy them from Resident 1. It went on for about a month after the sweatshirts were

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taken where [Resident 1] didn't get paid. [Resident 1] was complaining about not getting paid for them. I went in sometime approximately a week or so ago and gave [Resident 1] $50.00. I didn't know how much the sweatshirts cost but wanted to make things right. I told [Resident 1] to let me know if s/he needed more for the sweatshirts. [Administrator A] confirmed [s/he] took the sweatshirts and the transaction never took place... I looked at it as a simple, hey let's fix this and move on. Now if we were talking about a $500 transaction, that might be a little different. I went in and offered $50 the day after it was brought to my attention from [MCO].

Licensee B stated s/he was notified by Resident 1's MCO of the above concern, and stated Administrator A did not report it.

Licensee B stated s/he trusted Administrator A and did not see a problem with him/her going in and offering $50.00 to remedy the situation. Licensee B did not think an investigation was necessary as s/he took care of the situation for Administrator A.

Licensee B further stated, "[Administrator A] told me [s/he] reordered the sweatshirts but I'm not sure when they were coming but [s/he] told me [s/he] ordered them. I'm trusting [Administrator A]'s word because [s/he] has always been trustworthy so I just took [his/her] word for it."

RECORD REVIEW

On 06/07/2024 at approximately 9:15 AM, Surveyor requested Administrator A submit documentation to show the date Administrator A placed the initial order through Walmart.com, approximately 4 weeks ago, and the second

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order, approximately 2 weeks ago on Amazon.com including the item, size, price, and total cost paid, for the sweatshirts.

On 06/10/2024 (3 days after request) at 4:07 PM, Surveyor received an email from Administrator A that read, in part:

"Attached are the delivery dates for the sweatshirts. One was delivered on Sunday, so I brought that in, and it was given to [him/her]. I will email you the picture of the other one upon arrival. It should be here today or tomorrow."

The email contained a screenshot photo provided by Administrator A that showed delivery dates of 06/10/2024 and 06/11/2024 for 2 sweatshirts ordered. One photo showed 1 sweatshirt was ordered and had a total shipment cost of $12.82. It did not show the date it was ordered, or the size. The second photo showed another sweatshirt in black was ordered but did not show the date the order was placed, the size of the sweatshirt or the total cost of the shipment as requested on 06/07/2024.

The provider did not have documentation related to the above allegation or series of events that took place between Administrator A, Licensee B and Resident 1. Documentation was not available to show Resident 1's concern was investigated.

Licensee B did not take immediate steps to ensure the safety of all residents and did not initiate an investigation into Administrator A when Resident 1 expressed concerns of misappropriation of personal property. Interviews were not conducted, documentation was not requested, and Administrator A did not reorder sweatshirts as stated after s/he took sweatshirts

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N 158	Continued From page 4 purchased by Resident 1 for his/her (Administrator A)'s family member to use. Cross Reference N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from misappropriation of property. Findings include: On 05/14/2024, the Department received a complaint regarding resident care. INTERVIEWS On 05/28/2024 at approximately 12:30 PM, Surveyor interviewed Resident 1 in his/her room. Resident 1 stated s/he did not want to talk in the building as s/he was not comfortable. Resident 1 instructed Surveyor to reach out to his/her	N 348		

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managed care organization (MCO) case manager for all his/her concerns.

On 05/29/2024 at approximately 9:45 AM, Surveyor spoke to Nurse Case Manager (NCM) C via phone. NCM C informed Surveyor that Resident 1 had purchased sweatshirts that were too small and Administrator A stated s/he would take them for him/herself or his/her child, and would replace them with larger ones, approximately one month ago. Resident 1 informed Surveyor last week that Licensee B gave him/her $50 for the sweatshirt/hoodies since Administrator A had not ordered the replacement sweatshirts in a larger size to replace the sweatshirts s/he had taken.

On 06/07/2024 at 8:10 AM, Surveyor interviewed Licensee B via phone and asked if s/he was made aware Administrator A had taken sweatshirts from Resident 1. Licensee B stated, "Yes, [Resident 1] had a complaint about [Administrator A]. [Resident 1] had ordered sweatshirts that were too small and talked to [Administrator A] who offered to take the small ones and buy them from Resident 1. It went on for about a month after the sweatshirts were taken where [Resident 1] didn't get paid. [Resident 1] was complaining about not getting paid for them. I went in sometime approximately a week or so ago and gave [Resident 1] $50.00. I didn't know how much the sweatshirts cost but wanted to make things right. I told [Resident 1] to let me know if s/he needed more for the sweatshirts. [Administrator A] confirmed [s/he] took the sweatshirts and the transaction never took place... I looked at it as a simple, 'Hey let's fix this and move on.' Now, if we were talking about a $500 transaction, that might be a little different. I went in and offered $50 the day after it

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was brought to my attention from [MCO]."

Licensee B further stated, "[Administrator A] told me [s/he] reordered the sweatshirts but I'm not sure when they were coming but [s/he] told me [s/he] ordered them. I'm trusting [Administrator A]'s word because [s/he] has always been trustworthy so I just took [his/her] word for it."

Surveyor asked Licensee B why Resident 1 was still waiting for sweatshirts if they had been reordered. Licensee B suggested there could be a delay for when the sweatshirts would be delivered, and informed Surveyor s/he did not inquire any further about the transaction Administrator A stated had occurred.

On 06/07/2024 at 9:00 AM, Surveyor interviewed Administrator A and Licensee B via phone. Surveyor asked Administrator A for information regarding Resident 1's sweatshirt purchase. Administrator A stated, "[S/he] ordered a sweatshirt and they came too small. [S/he] wanted assistance returning them but instead of returning them for a larger size, I told [him/her] I would take them because they would fit my [child]. I reordered sweatshirts in a larger size for [Resident 1] 4 weeks ago through Walmart online but I entered my card number wrong and had to reorder them 2 weeks ago through Amazon. I don't know why they haven't come yet; I'll have to check up on that. They're still not here... The reason I reordered them was because the ones [s/he] had originally ordered were the same size as my [child] wears so I kept them and offered to reorder them."

RECORD REVIEW

On 06/07/2024 at approximately 9:15 AM,

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N 348	Continued From page 7 Surveyor requested Administrator A submit documentation to show the date Administrator A placed the initial order through Walmart and the second order approximately 2 weeks ago on Amazon, including the item, size, price, and total cost paid, for the sweatshirts. On 06/10/2024 (3 days after request) at 4:07 PM, Surveyor received an email from Administrator A that read, in part: "Attached are the delivery dates for the sweatshirts. One was delivered on Sunday, so I brought that in, and it was given to [him/her]. I will email you the picture of the other one upon arrival. It should be here today or tomorrow." The email contained a screenshot photo provided by Administrator A that showed delivery dates of 06/10/2024 and 06/11/2024 for 2 sweatshirts ordered. One photo showed 1 sweatshirt was ordered and had a total shipment cost of $12.82. The documentation provided by Administrator A did not show the date it was ordered, or the size. The second photo showed another sweatshirt in black was ordered but did not show the date the order was placed, the size of the sweatshirt or the total cost of the shipment as requested on 06/07/2024. SUMMARY Resident 1's property was misappropriated when Administrator A took sweatshirts purchased by Resident 1 that did not fit Resident 1. Administrator A stated s/he would reorder sweatshirts in a larger size in exchange for taking the sweatshirts for his/her child but did not	N 348		

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N 348	Continued From page 8 replace the sweatshirts in a larger size for Resident 1 until questioned by the Department. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 348		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was involved in developing the individual service plan (ISP) when the ISP was not signed by Resident 1 acknowledging their involvement in, understanding of, and agreement with, the plan. Findings include:	N 387		

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N 387	Continued From page 9 On 05/14/2024, the Department received a complaint regarding resident care. On 05/28/2024, Surveyor reviewed Resident 1's record. Resident 1 had an admission date of 02/26/2024. The record contained an ISP but the ISP did not contain any signatures or dates to indicate review of the plan. On 05/28/2024 at 12:35 PM, Surveyor interviewed Resident 1 and asked if the provider reviewed his/her ISP with him/her or if s/he had seen a written ISP related to care needs. Resident 1 stated s/he had not been asked to sign anything and was not invited to participate in any meetings related to his/her care needs. On 05/28/2024 at 12:48 PM, Surveyor interviewed Administrator A and asked if Resident 1 was involved in the development of his/her ISP. Administrator A stated, "[S/he] may not have signed it. I start the ISP on admission and add to it." Administrator A stated s/he did not review the ISP with Resident 1 and was aware of the requirement.	N 387		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by:	N 450		

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N 450	Continued From page 10 Based on observation and interview, the provider did not ensure weekly written menus were prepared and did not make menus available to residents. Findings include: On 02/06/2024, the Department received a complaint regarding menus. On 05/28/2024, Surveyor entered the facility and observed a whiteboard near the entrance containing the date, weather, staff working and the menu for the day: Breakfast: Hot/cold cereal, bacon, orange slice. Lunch: [Brand Name] Bowls (mashed potatoes, chicken tenders, corn, gravy). Dinner: Cheeseburger casserole. Surveyor toured the facility and did not observe a weekly menu posted. On 05/28/2024 at approximately 11:00 AM, Surveyor interviewed Cook C. Cook C stated s/he completes the meal planning and orders the food. Cook C informed Surveyor the daily menu is posted on the whiteboard at the entrance but a weekly menu is not made available to residents in advance. Surveyor asked Cook C if s/he had prepared a menu for the week. Cook C stated s/he did have the weekly menu planned, but the menu was not provided to Surveyor for review.	N 450		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as	Y3244		

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Y3244	Continued From page 11 provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility after admission to the facility on 02/26/2024. Resident 1 developed open areas on lower extremities and was hospitalized on 03/26/2024. The provider identified staff were not consistently and appropriately wrapping Resident 1's legs, and delayed staff training by approximately 1 month after Resident 1 was admitted. Findings include: On 05/14/2024, the Department received a complaint regarding resident care. On 05/28/2024 at approximately 10:35 AM, Surveyor interviewed Administrator A and asked if any residents had open wound areas. Administrator A stated Resident 1 went out for wound care and saw his/her primary care	Y3244		

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Y3244	Continued From page 12	Y3244		

physician (PCP) for follow-up. Administrator A stated staff were no longer responsible for Resident 1's wound care. Administrator A stated Resident 1 developed sores after s/he was admitted and a nurse from an outside source was being utilized for monthly wound assessments. Administrator A stated Resident 1's care team expressed concerns regarding wound care and had requested more nursing care. Surveyor requested Resident 1's record from Administrator A.

On 05/28/2024, Surveyor reviewed Resident 1's record. Resident 1 had an admission date of 02/26/2024 and the diagnoses list included the following: chronic diastolic (congestive) heart failure, lymphedema, pressure ulcer left hip, pressure ulcer of other site-stage 2, non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity, gout, pain in right lower leg, pain in right knee, and bradycardia.

Surveyor reviewed admission orders under the admission tab in Resident 1's physical chart provided by Administrator A. The admission orders located behind the "admission" tab, dated 02/07/2024 from a hospital visit, read, in part:

-Open wound of left hip: Chronic in nature due to lymphedema, excessive fluid intake resulting in weeping and blistering of left upper lateral thigh and hip. Wound comes and goes. Continue monitoring and current wound care: Zinc oxide to left hip, apply Aquaphor to remaining irritated skin on left hip.

-Lymphedema of lower extremity: As above. Encourage compliance with fluid restrictions. Continue wound care to left hip, Ace wraps, zinc

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Y3244	Continued From page 13 oxide, Aquaphor. Resident 1 did not have open areas on lower extremities upon admission. Surveyor reviewed the hospital visit summary note, dated 03/28/2024. The note stated Resident 1 presented with worsening lower extremity edema and weeping sores after moving into the assisted living facility a few weeks ago. Resident 1 reported his/her wound care had "taken a back seat" as the staff at the facility did not want to wrap his/her legs. Resident 1 stated that as a result, his/her legs had gotten larger and developed superficial sores with clear drainage. The note further stated Resident 1 was admitted for "possible acute on chronic R HF exacerbation vs worsening edema due to lack of compression from recent assisted living facility change resulting in less attention being paid to his/her cares. Resident 1 was given IV (intravenous) diuretics with net diuresis of 2.7L (liters) with stable creatinine and lytes. Wound care nurse evaluated and made recommendations noted above ...It is critical [s/he] have close attention paid to the lower extremity compression and wound care going forward." The wound care orders upon discharge from the hospital on 03/28/2024 read, "Active orders, skin & wound care, apply ace wrap/elastic compression bandage until specified. Remove every shift for skin assessment. Remove if any signs/symptoms of circulatory compromise or patient complains of pain. Daily wound care orders: 1. Daily wound care to bilateral lower legs: Cleanse area with mild soap and water. Pat dry. RIGHT 2nd TOE: Paint with iodine and allow to	Y3244		

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	0019052	A. BUILDING: _____ B. WING _____	C 06/11/2024

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dry. LEGS: Apply Vaseline to wound edges. Cut a piece of Adaptic (oil emulsion gauze) to fit size of wound. Lightly coat with Medi honey and apply to wound bed. Cover with ABD. Hold in place with rolled gauze. Apply tubi F toes to ankle and tubi H ankle to just below the knee. Apply comprilan wraps toes to just below knee.

2. Twice daily cares to knee folds, gluteal cleft, left breast fold: Wash skin folds with mild soap and water. Dry thoroughly. Apply Miconazole to reddened areas. Place viva paper towel in skin folds, ensuring it is placed all the way to the base of the fold, to minimize skin to skin contact.

3. Daily and prn (as needed) cares to left lateral thigh: Cleanse with mild soap and water. Pat dry. Cut a piece of Mesalt to fit size of wounds and place over wound bed. Cover with ABD and secure with medipore tape.

Surveyor reviewed Resident 1's task administration record (TAR) for February and March 2024. The following information was identified:

-The February TAR did not have wound care or leg wraps scheduled for staff to document as ordered upon admission.
-Staff did not document wound care to left hip until 03/06/2024.
-Staff did not document leg wraps until 03/19/2024.

Surveyor reviewed progress notes for Resident 1. The progress notes showed Resident 1 required staff assistance with leg wraps in the morning and taken off in the evening upon admission on 02/26/2024. Staff charted the following notes, which read, in part:

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Y3244	Continued From page 15 -03/04/2024: Assisted with taking wraps off legs. -03/06/2024: Resident claimed weight gain because wraps were not tight. Staff reminded resident s/he complains when wraps are too tight. -03/07/2024: Wound care completed. Legs were more swollen and had blisters on the ankles and going up the leg. -03/11/2024: Legs were "oozing" when staff unwrapped legs. -03/13/2024: Appointment with nurse practitioner at clinic. Set up wound care. -03/14/2024: Reported an open spot from brief rubbing. Staff assessed and found an open area. Staff applied Mepilex. -03/16/2024: Resident had legs wrapped at 4:30 AM. Legs were leaking fluid. -03/16/2024: Both legs were re-wrapped as wraps were falling off the left leg and was too tight on the right leg. -03/17/2024: Legs were "oozing really bad." There was a "puddle of fluid on the floor" under resident's legs. -03/26/2024: Wound nurse requested resident be sent out for wounds on legs to check for Cellulitis. -03/29/2024: Resident was sent to hospital due to increased edema and weeping from lower extremities and returned from the hospital on 03/28/2024. Had several "open and weeping areas" on both lower extremities. -03/31/2024: Some sores were weeping on left lower leg. Edema in legs was "better." Top of each foot remained swollen. -04/01/2024: Resident requested wraps taken off early because they were cutting off circulation. Left leg was very sore with blood and yellow fluid draining. Right leg did not appear "as bad but was oozing yellow discharge. Picture taken and sent to wound nurse for further instruction. Fax sent to PCP regarding cardiac referral and wound	Y3244		

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referral," but resident did not wish to go to the wound clinic for evaluation.
-04/07/2024: Resident complained socks were too tight on ankle. Took them off around 4:00 AM.
-04/11/2024: Yellow and green discharge and "increased oozing with bleeding."
-04/22/2024: "Wound care done to lower extremities for 3 open areas on left lower extremity on the front of lower leg. They measure 1cm (centimeter) x 1cm, 2cm x 2cm, 1.5cm x 1.5cm. Open area on right inner ankle measuring 1.5cm x 1cm. Wounds draining minimal amount of drainage. Edema reduced greatly and top of foot is not as puffy. Right lower extremity open areas on front of right leg measure 3cm x 2.5cm, 4.5cm x 3cm, 1.5cm x 2cm. Open areas on right inner ankle back of leg measuring 12cm x 6cm. These wounds were draining a minimal amount and edema is reduced in size. Top of right foot also less puffy."

Surveyor reviewed a document with the title, "Visit Report for 4/25/2025," which was a wound assessment of the following areas:

-Wound #4: Left, anterior lower leg is full thickness venous ulcer, status not healed.
-Wound #5: Left, distal, medial lower leg is chronic full thickness ulcer, status not healed.
-Wound #6: Right, anterior lower leg is full thickness venous ulcer, status not healed.
-Wound #7: Right, medial lower leg is full thickness venous ulcer, status not healed.
-Wound #8: Right, lateral lower leg is full thickness venous ulcer, status not healed.

On 05/28/2024 at approximately 11:20 AM, Surveyor interviewed Caregiver D about Resident 1's care. Caregiver D stated Resident 1 did not have wounds when s/he was admitted. Caregiver

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D further stated, "We were wrapping][his/her] legs with wraps, and [s/he] had edema, so we were told to wrap them tighter, and [s/he] developed blisters. [S/he] was sent out to the hospital for a few areas that opened. I don't do any wound care but was wrapping [his/her] legs with the ace wrap the best I could. Caregiver D stated s/he offered to do them but could not recall if s/he received training specifically for Resident 1's leg wraps.

On 05/28/2024 at 11:45 AM, Surveyor interviewed Administrator A about the frequency of Resident 1's leg wraps and what lead to open areas noted on the hospital visit summary approximately one month after Resident 1 was admitted. Administrator A stated Resident 1 was admitted with leg wraps, and they were training staff how to wrap for edema. Administrator A stated Resident 1 developed cellulitis and they increased the number of "wrap checks" to 4 times per day since the wounds developed beginning 03/27/2024. Administrator A stated the nurse from [Company Name] who was doing the monthly wound care assessments provided a training on how to properly wrap for compression.

On 05/28/2024 at approximately 12:30 PM, Surveyor interviewed Resident 1 and asked what care was received since admission. Resident 1 stated s/he did not have wounds on his/her legs when s/he arrived at the facility, and was relieved staff were no longer responsible for wrapping his/her legs. Resident 1 stated staff refused to wrap and did not feel comfortable wrapping his/her legs appropriately. Resident 1 stated s/he felt the lack of staff training on how to wrap his/her legs impacted the development of wounds. Resident 1 stated there was one staff member who would wrap his/her legs and it was

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Y3244	Continued From page 18 not getting done when s/he first moved in. On 05/28/2024 at 1:00 PM, Surveyor requested staff training documentation for Resident 1's leg wraps from Administrator A. On 05/30/2024 at 10:00 AM, Surveyor reviewed the staff training form received via email from Administrator A. The training form provided by the nurse utilized for monthly wound care assessments was provided for one staff member (Caregiver E). There was no date listed on the training form. On 05/30/2024 at 11:47 AM, Administrator A informed Surveyor the training was provided on 04/11/2024. The second page of the attachment sent via email showed a staff meeting signature sheet for a staff meeting held on 03/22/2024, with Administrator A as the instructor. The following meeting topics were identified: "CPR, WR, UA, Vitals, Wraps/TEDS." Twelve employees attended the meeting. The content/training materials were not provided to show what staff were trained on for the meeting topics listed. The provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility after admission to the facility on 02/26/2024, when staff assistance with wound care and leg wraps were delayed.	Y3244		