Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329131902M
Compliance #: HL329133193C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee Investigated:
Volante of Hanover
10875 Settlers Lane
Hanover, MN 55341
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to provide health care, medications, and services to address the resident's changing health status. As a result, the resident had multiple falls. One fall resulted in the resident laying on the floor for five hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident developed a systemic rash (whole body) and physician's discontinued various medications to determine the cause of the rash. Although the facility failed to discontinue medications accurately, it was not likely these medication errors contributed to the resident falling. The resident had multiple chronic medical diagnoses which effected the resident's gait (walking) and balance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

pharmacy records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, meningioma (brain tumor), kidney failure, and diabetes. The resident's service plan included assistance with medication management. The resident's nursing assessment indicated the resident had severe memory loss and required frequent redirection from staff members. The nursing assessment indicated the resident was at risk for falling because she had a history of falling and her diagnoses included seizures and a brain tumor.

Progress notes indicated the resident's neck and chest was "red" when she admitted into the facility because she received radiation treatment for a brain tumor. Progress notes indicated the resident began to scratch at her skin and had a few open wounds. Approximately one week later, progress notes indicated the resident's rash was all over her body. The resident had blisters, and swelling of her lower limbs. Progress notes indicated the resident went to the emergency room (ER) and returned to the facility with physician orders for new medications and an order to discontinue (stop) taking the medication Lexapro (medication used to treat depression and anxiety).

Physician visit records indicated the resident's family contacted them through a message portal system six days later because the resident's rash had not improved since the physicians discontinued the Lexapro. The records indicated the physician wanted to discontinue another medication called Depakote (used to prevent seizures and treat mood disorders).

Medication administration records (MAR) indicated the facility did not discontinue medications Lexapro and Depakote when ordered by the physician; the resident remained on those medications.

Facility Incident reports indicated the resident fell five times within the same month. The resident fell twice in one day which resulted in hospitalization.

Progress notes written by the nurse indicated staff members found the resident on the floor in her room around 7:30 a.m. The progress notes indicated staff members who worked the night shift offered the resident help to get to the bathroom, however she declined. They went back into the room to check on her and saw a "scrape" on her nose. The resident denied falling. The progress notes indicated the nurse observed the resident "crossing over" her feet as she walked which caused her to be unsteady. The progress notes indicated this behavior had occurred before, so the nurse told staff members to walk with the resident The progress notes lacked indication between the time staff members offered the resident assistance to the bathroom to the time they found her.

There were no further progress notes regarding the resident's fall in the evening, however the nurse completed an incident report, the same day, later in the evening.

Facility incident report indicated the resident fell in the evening at 6:30 p.m., in her bathroom and sustained a cut to the back of her head. Staff members sent the resident to the ER. The incident report indicated the resident had improper shoes on at the time of the fall.

Hospital records indicated physicians diagnosed the resident with major neurocognitive disorder due to Alzheimer disease, with behavior disturbance, acute delirium (sudden change in memory), and cognitive decline. Hospital records indicated the resident had a rapid mental decline and weakness of the right side of her body. The records indicated the resident's brain tumor contributed to her memory decline and poor balance. Physicians ordered hospice care (end of life) for the resident due to her rapid cognitive decline, and weakness.

Medical examiner records indicated the resident died approximately one month later from dementia (brain disease).

During an interview, a nurse said the resident had multiple health issues including a brain tumor. The nurse said the resident had memory problems, psychosis (delusions/hallucinations), exit seeking behaviors, and aggression. The nurse said the resident's behaviors occurred more frequently during the evening. The nurse said staff members who worked with the resident during the night called her and told her the resident fell so she went to the facility. The nurse said there was miscommunication between the two shifts of staff members about what occurred. The nurse said she interviewed the staff members when she arrived, called the resident's family, and physician. The nurse said she no longer worked at the facility and could not remember details about the resident's falls, but said her documentation about the falls was accurate. The nurse said there were multiple leadership team members who completed the investigation into the resident's falls.

Both staff members working at the time of the fall failed to respond to request for interviews.

During an interview, a manager said the resident's family member told him they were concerned the resident was on the floor for an extended period. The manger said both staff members who worked at the time told him they were in a room right next to the resident's room, and they responded timely. The manager said there were no cameras in the resident's room and cameras outside the resident's room did not show anything significant.

During an interview, a family member said a staff member called her in the morning and told her the resident fell. The family member said she arrived at the facility, prior to the nurse, and saw the resident on the floor with dried blood on her face. The family member said staff members were trying to get her into a chair. The family member said a staff member told her there was a pillow and blanket with the resident at the time they found her on the floor. The family member said she did not see the pillow and blanket at the time she arrived. The family

member said once the resident was up, she stayed with her at the facility for the morning. The family member said later in the evening the facility called her and told her the resident fell again so they sent her to the ER. The family member said the resident admitted into the hospital for medical evaluation. The family member said the resident stayed in the hospital for approximately one week and discharged to a different facility. The family member said the resident was no longer able to walk when she discharged from the hospital.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided dementia training for staff members.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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	32913	A. BUILDING: _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLANTE OF HANOVER	10875 SETTLERS LANE HANOVER, MN 55341

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL329133230C/HL329131922M HL329133193C/HL329131902M On June 11, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 15 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL329133230C/HL329131922M, tag identification 1690, 2360. There are no correction orders are issued for HL329133193C/HL329131902M.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01690 SS=G	144G.71 Subdivision 1 Medication management services	01690		

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01690	Continued From page 1 (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based in interview and record reviewed, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. The licensee failed to take ownership of their entire medication	01690		

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01690	Continued From page 2 administration system and differed responsibility to the pharmacy. As a result of this deficient practice, when R1 had an allergic reaction with a rash that persisted, physician's continued discontinuing medications under the assumption their order of a previous medication was implemented and the rash was the result of a different medication. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, ore death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally.) The findings include: R1's diagnoses included Alzheimer disease, chronic renal insufficiency, and diabetes. R1's service plan dated March 5, 2025, included assistance with medication management. Progress notes dated February 24, 2025, at 5:39 p.m., indicated R1 developed a rash on her neck and chest. The licensee updated R1's physician. Progress notes further indicated by March 2, 2025; the rash was "all over." R1 had blisters, and edema of her lower extremities. R1 went to the emergency room (ER) the next day on March 3, 2025. R1 returned to the licensee with new medication orders from the physician. Escitalopram: R1's hospital after visit summary (AVS), dated March 3, 2025, indicated physicians ordered R1 to stop taking Escitalopram (lexapro).	01690		

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01690	Continued From page 3 Progress notes dated March 3, 2025, at 5:38 p.m., indicated R1 returned from the hospital with new medication orders including an order to discontinue lexapro. R1's medication administration record (MAR) dated March 1, 2025, through March 30, 2025, indicated the licensee did not discontinue escitalopram until March 20, 2025. However, a duplicate order was also on the MAR and R1 received an additional dosage of the medication on March 25, 2025. The MAR indicated the licensee failed to discontinue the as needed "PRN" dosage of the medication, and R1 received PRN dosages on March 20, 21, 22, and 23. The licensee discontinued the PRN medication on March 26, 2025. The licensee failed to discontinue the escitalopram as ordered by the ER physician on March 3, 2025. R1 received 21 dosages of escitalopram after the ER physician discontinued the medication. Depakote: Physician records dated March 9, 2025, indicated a family member contacted them through a portal system (similar to email) because R1's rash did not improve after ER physicians discontinued the escitalopram on March 3, 2025. (However, the licensee failed to discontinue R1's escitalopram.) Because there was no improvement in R1's skin condition after the discontinuation of escitalopram and addition of a steroid medication (prednisone), they wanted the licensee to discontinue Depakote (medication used to treat seizures and mood disorders). The physician's documentation indicated the licensee should discontinue Depakote.	01690		

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01690	Continued From page 4 Fax Transmission form dated March 10, 2025, at 2:16 p.m., indicated R1's clinic sent the licensee a fax message indicating R1 should stop Depakote "stat" (immediately). The fax included the name and telephone number of the nurse who sent the licensee the fax, and included a message to call her if the licensee needed anything else. The fax contained handwritten initials from the licensee's nurse with the date March 11, 2025. The fax also included "D/C" with handwritten initials from the licensee's nurse. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee did not discontinue Depakote until March 13, 2025, at 8:00 p.m. On March 24, 2025, at 8:00 a.m., the MAR indicated the licensee added another order for staff to administer Depakote. The MAR indicated staff gave R1 Depakote on March 24, 2025, but then discontinued the order again on March 25, 2025, at 8:00 a.m. The MAR indicated R1 received nine additional dosages of Depakote after R 1's physician ordered the licensee to discontinue the medication immediately. R1's progress notes lacked indication the licensee discontinued Depakote on March 9, 2025, or on March 10, 2025, as indicated on the fax. R1's progress notes dated March 27, 2025, indicated the licensee received a new order to discontinue Depakote on March 27, 2025. Doxycycline: Progress notes dated March 12, 2025, at 3:39 p.m., indicated the licensee received new medication orders from R1's dermatologist. The note indicated the new medications included Doxycycline 100 milligrams (mg) (antibiotic) twice daily. The progress notes dated March 27, 2025,	01690		

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01690	Continued From page 5 at 8:40 p.m., indicated the dermatologist ordered the licensee to discontinue Doxycycline. R1's MAR dated March 1, 2025, through March 30, 2025, indicated R1 already received Doxycycline prior to the appointment on March 12, 2025. There were two entries/orders for Doxycycline in the MAR, and it was unclear if the licensee communicated with R1's dermatologist, she was already receiving the medication at the time of the appointment on March 12, 2025 from R1's records. The start date for the medication was March 4, 2025, and the instructions on the MAR read as follows: Doxycycline hyclate 100 mg capsule: Take one capsule by mouth twice daily for seven days. No Refills. The licensee did not discontinue the medication after the seven days but continued to administer this medication twice daily until March 19, 2025, when the licensee entered a new order for the medication into the MAR. The MAR indicated the licensee did not discontinue the Doxycycline on March 27, 2025, and R1 continued to receive the medication on March 28, 2028. R1 was out of the facility on March 29, 2025, therefore she did not receive the medication, but the licensee did not discontinue the order from the MAR. Medicated Ointments: Progress notes dated March 12, 2025, at 3:39 p.m., indicated the licensee received new medication orders from R1's dermatologist. The note indicated the new medications included clobetasol ointment twice daily to rash and Denonide ointment. The progress notes indicated the physician sent the orders to the pharmacy. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee started Clobetasol and Desonide on March 19, 2025.	01690		

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01690	Continued From page 6 This was six days after the physician ordered the licensee to start these medications. The MAR included a duplicate order for Clobetasol, but staff members did not administer the medication from the duplicate order. Celexa: Physician records dated March 17, 2025, at 1:54 p.m., indicated R1's physician ordered Celexa 10 milligrams (mg) daily because it would not result in a rash or serious allergic reaction called Stevens-Johnson syndrome. The records indicated the physician faxed the licensee. R1's MAR dated March 1, 2025, through March 30, 2025, indicated the licensee did not start the medication until March 20, 2025. The MAR indicated the licensee discontinued the medication on March 25, 2025. The MAR included a duplicate order, so staff member gave R1 the medication again on March 28, 2025. The order continued to be on the MAR as an active medication for staff members to administer the medication. Physician after-visit summary dated March 27, 2025, at 12:15 p.m., indicated a dermatologist evaluated R1. The after-visit summary record indicated R1's medication list included Celexa 10 mg by mouth daily. R1's nursing assessment dated March 19, 2025, indicated R1 "currently" had skin conditions. The skin assessment indicated R1 would need a possible hospice evaluation (end-of-life), but did not further describe why R1 required hospice evaluation due to skin conditions. The assessment indicated R1 was orientated to herself, but was frequently disorientated and required repeated re-direction. The assessment	01690		

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01690	Continued From page 7 indicated R1 had occasional disruptive, aggressive, and socially inappropriate behaviors. The assessment indicated the R1 had a history of occasional hallucinations or delusions. The assessment indicated R1 walked with minimal assistance from staff. R1 was at risk of falling and contributing factors to fall risk included her history of falls, seizures, brain tumor January 25, 2025, and psychotropic medications. The section titled, "Challenging Behaviors" indicated R1's behaviors may affect the safety of the resident. The assessment indicated R1's behavior was poor hygiene, resistive to care assistance, unsafe smoking habits, wandering. This section of the nursing assessment indicated R1 required the medication "Divalproex" (Depakote) to manage her behaviors. Email communication from family member (FM)-F to registered nurse (RN)-B and licensed assisted living director (LALD)-C dated March 26, 2025 at 9:55 a.m., indicated FM-F met with RN-B and LALD-C on March 25, 2025, to review R1's care plan, however FM-F felt they did not resolve the discrepancies with R1's medication lists. FM-F indicated a physician had been attempting to reach the licensee to to discuss the medication discrepancies. FM-F wrote in her email R1's health was fragile and it was critical they ensure she was receiving the correct medications and dosages of those medications. RN-B responded to the email March 26, 2025, at 11:21 a.m., RN-B's response indicated she reviewed R1's medications with neurology and was waiting for them to send her orders. RN-B wrote, "I agree on prioritizing. I have a Nursing practice act, I must follow." RN-B indicated the licensee set up an improved communication stream line. FM-A responded to RN-B at 12:59 a.m. FM-A indicated R1 had a medical appointment on March 27,	01690		

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01690	Continued From page 8 2025, and she wanted RN-B to provide a new medication list with any new medications prescribed by neurology. Facility incident log dated March 17, 2025, through March 28, 2025, indicated R1 fell five times and went to the ER twice due to injuries from her falls. On March 28, 2025, at 6:30 p.m., R1 fell and cut her head. She went to the hospital and did not return to the licensee. Email communication from the pharmacy to LALD-C, dated April 8, 2025, at 10:21 a.m., indicated the pharmacy did not receive any orders/communication to discontinue escitalopram or divalproex, so they continued to refill and send the medications. The email communication did not include information regarding Celexa. On June 11, 2025, at 12:33 p.m., operations specialist (OP)-A said R1's family emailed management over concerns R1 was not receiving medications correctly, however OP-A said she had limited knowledge about the incident and thought what occurred was the family had an old/not updated "face sheet" (list of medications). OP-A said sometimes when the physicians order new medications they send the order straight to the pharmacy, other times they give the order to the nurse. OP-A said management received an email from R1's family, and she heard discussions from the facility nurse that sometimes R1 went to a doctor and returned with documentation, but not an actual physician order. OP-A said she was unsure if the facility nurse could enter new orders into the licensee's computer system, or if only the pharmacy entered orders into the computer system. OP-A said the licensee is currently working on licensure order	01690		

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01690	Continued From page 9 corrections from prior survey. On June 16, 2025, at 2:41 p.m., RN-B said the pharmacy entered the physician orders into the licensee's computer system, however she would have to "verify" the order. RN-B said she also "could" enter orders into the licensee's computer system, but she did not enter medications orders into the computer system because the pharmacy did. RN-B said some physicians faxed orders to the pharmacy directly, others did not. RN-B said she faxed medication orders to the pharmacy for the physicians who did not fax the pharmacy directly, and this process would take longer. RN-B said she was aware the MAR included duplicate orders. RN-B said this occurred because the pharmacy would not discontinue medication orders from the MAR, and would re-send medication. RN-B said once she became aware of the duplications, she spoke to upper management and the pharmacy. RN-B said unlicensed personnel (ULP) would tell her if they noticed duplicate orders. RN-B acknowledged other resident's had medication duplications on their MARs, but said she did not think any harm occurred to them. On June 24, 2025, at 7:58 a.m., LALD-C said R1 was on numerous medications and her family wanted other medications added, however the nurse did not have physician orders to add them. LALD-C said they started digging into pharmacy records and discovered there were some medications the licensee should have discontinued for R1, but they had not. LALD-C said the pharmacy never received orders to discontinue medications. LALD-C said the licensee's team spent several hours trying to sort things out, and described this process as "a mess." LALD-C said he was unaware if the	01690		

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	32913	A. BUILDING: _____ B. WING _____	C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01690	Continued From page 10 licensee's team went through other resident's records to ensure accuracy. LALD-C said the licensee made no changes to their medication processes because this was an isolated incident. On June 25, 2025, at 1:38 p.m., regional director (RD)-E said she was part of the leadership team who tried to investigate concerns regarding R1's medications. RD-E said they discovered there were errors with RN-B's documentation process. RN-B documented inaccurately, not based on facts. RN-B documented physician order changes, however the licensee did not have an official physician order at the time she documented in R1's progress notes. RD-E said R1's progress notes, did not match the medication portal system. RD-E said the pharmacy entered in resident medication orders into the licensee's computer system, the nurses did not. RD-E said the nurse "could" enter in a treatment order, but not a medication order. RD-E said RN-B could "stop" a medication; however, they would then have to provide an order to the pharmacy otherwise the pharmacy would re-start the order. RD-E was unclear if the facility nurse would know if the pharmacy re-started an order. RD-E acknowledged there were communication errors with this process. RD-E said the licensee's process for medication reconciliation occurred daily as the nurse would check the computer system's dashboard, and check the licensee's fax machine for new orders. RD-E acknowledged the MAR contained duplicate orders and said the team spent hours trying to understand what occurred. RD-E said the licensee has made no changes to their medication ordering system. On June 30, 2025, at 11:35 a.m., FM-F said she told RN-B about R1's medical appointments in advance and she would give her "paperwork" to	01690		

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01690	Continued From page 11 take to the medical appointment. FM-F said she returned the paperwork from the medical appointment to the licensee. FM-F said she noticed discrepancies with R1's medication list three times and spoke to RN-B about those discrepancies. FM-F said RN-B told her she could not take orders from a family member, but FM-F said she gave RN-B the orders from R1's medical appointments. FM-F said R1's physicians were trying to determine what caused R1's systemic rash and blisters. FM-F said initially the ER physician stopped R1's escitalopram, then Depakote. FM-F said she assumed the licensee stopped these medications, but they had not. FM-F said R1 fell multiple times, and had a lot of behavior changes. FM-F said R1 went to the hospital after she fell twice in one day and the physicians tested her blood and discovered she still had Depakote in her system. FM-F said physicians determined Depakote caused R1's rash. FM-F said physicians determined the inaccurate dosages of escitalopram contributed to R1's behavior issues and multiple falls. The licensee's policy titled, Medication and Treatment Orders - Implementing, dated May 28, 2025, indicated the licensee would implement medication orders within 24/hours of receipt of a medication order from a physician. The policy indicated the original signed order or fax order would be placed in a designated place for the nurse to review and sign at the next scheduled nurse visit. Time period for correction: Fourteen (14) days.	01690		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 12 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		