AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

State Long-Term Care Manager Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 27, 2023

Ms. Lynne Stratton, Manager
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Stratton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 19, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: ______ B. WING ______	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

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R100	Initial Comments: An unannounced onsite re-licensure survey was conducted by the Division of Licensing and Protection on 6/19/23. The following regulatory violations were identified:	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Registered Nurse (RN) failed to ensure 2 out of 8 resident records contained an annual reassessment and a significant change assessment (Residents #1 and #2). Findings include: 1. Per record review Resident # 1 was admitted to the Residential Care Home (RCH) on 5/16/22, an annual reassessment was not completed in the year 2023, additionally the record did not contain a change in condition assessment to identify care needs related to recent admission to hospice services. Per interview on the afternoon of 6/19/23 administration confirmed there was no evidence in the medical record that an annual assessment or a change in condition assessment was	R136	**#1-- R136-Resident Care and Home Services** The annual assessment for resident # 1 was completed to include change of condition and hospice services. The annual assessment on resident # 2 was completed with changes of condition. Completion 6/20/23. The HWD and nursing designee have been retrained on the Vermont annual assessment regulation requirements by the Executive Director as of 6/20/23. The HWD and nurse designee will keep a tracker of annual assessments to track due dates The HWD and ED will meet monthly to review annual assessments and any resident change of conditions to verify compliance, monthly ongoing. Tag R136 accepted on 7/27/2023 - S.Freeman	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynne Stratton
TITLE: Executive Director
(X6) DATE: 7/18/2023

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R136	Continued From page 1 completed. 2. Per record review Resident #2 was admitted to the RCH on 4/23/19. There was no evidence of an annual assessment completed in 2020 and a significant change reassessment completed when Resident #2 was admitted to hospice on 5/28/2021 in his/her record. At 1:40 PM on 6/19/23 the Health and Wellness Director confirmed an annual reassessment for 2020 and a change of condition assessment when Resident #2 was admitted into hospice care on 5/28/2021 were not on file and available for review in Resident #2's health record.	R136		
R160 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.	R160		

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R160	Continued From page 2 (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to ensure that outdated and unused medication were removed and disposed of per facility policy. Findings include: Per observations of the medication storage room on the special care unit made during the initial tour of the facility on 6/19/2023 at approximately 10:30 AM there were several medications being stored in the cabinets that were expired or no longer in use. The medications included 5 boxes of Lidocane Pain Relief Patches with expiration dates of 5/2022, a bottle of 81 mg Aspirin expiration 2/2022, Folic Acid expired 1/2023 and two bottles that expired on 4/7/2023, Methotrexate 6/16/2023, and Amlodepine that expired on 3/17/2023. Per interview with the medication Tech on the special care unit at approximately 10:30 AM it is facility policy that non controlled expired or unused medications are placed in the drug destruction box located in the medication storage room. The Medication Tech confirmed that the	R160	**#2--R160- Resident Care and Home Services** 1. Expired drugs were placed in the drug destruction boxes immediately following survey. 2. Medication administration associates have been retrained by the Health and Wellness Director (HWD) or nurse designee on the Medication and Disposal Policy as of 6/20/23. The lead medication technicians in AL and MC will monitor the med carts and medication storage room daily to verify that expired drugs are placed in the designated destruction boxes. 3. The HWD will make routine rounds to verify compliance, 6/20/23 and ongoing. Tag R160 accepted on 7/27/2023 - S.Freeman	

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R160	Continued From page 3 medications listed above were expired and/or unused and they should have been removed from the cabinet and placed in the drug destruction box per policy.	R160		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure signed orders for one applicable resident (Resident #2) were on file and available for review. Findings include: Per record review Resident #2's physician's orders signed on 6/24/2022 include Lorazepam 0.5 mg tablet Give 2 tablets sublingually every 4 hours for nausea and restlessness. However, his/her June 2023 Medication Administration Record (MAR) lists Lorazepam 0.5 mg tablet Give 1 tablet every 4 hours as needed for nausea/restlessness, and an additional scheduled dose of Lorazepam 0.5 mg tablet Give 1 tablet at 6:00 AM and 6:00 PM for anxiety/restlessness. On the afternoon of 6/19/23 the Executive Director confirmed Resident #2's record did not contain signed physician's orders that reflect these changes.	R162	**#3--R 162- Resident Care and Home Services** 1. Orders for Resident #2 were sent to the primary care provider immediately after survey for signature verification. 2. Nursing staff have been retrained on the Medication & Treatment - General Guidelines for Medication Administration/Assistance policy and staff acknowledging that orders do not go into the eMAR until there is a confirmation signature from the primary care provider. Completed as of 6/20/23. 3. The HWD or nurse designee will conduct weekly audits X 4 weeks then routinely thereafter to verify compliance. Tag R162 accepted on 7/27/2023 - S.Freeman	

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R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to develop a written plan for the use of a PRN psychoactive medication for one applicable resident (Resident #2). Findings include: On review Resident #2's record did not include a written plan for the administration of PRN (as needed) Lorazepam by unlicensed staff which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.	R167	**#4--R 167- Resident Care and Home Services** 1. Resident #2 Personal Service Plan was updated immediately following survey to reflect a written care plan for the use of PRN psychoactive medications. 2. The HWD and nursing designee have been retrained on the Vermont regulation requirements regarding psychoactive medication use and care planning by the Executive Director as of 6/20/23. 3. The HWD and ED will review residents who use psychotropic medication and verify there is a written care plan on a monthly basis to verify compliance, to be completed by 7/31/23 and ongoing. Tag R167 accepted on 7/27/2023 - S. Freeman	

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R167	Continued From page 5 On the afternoon of 6/19/23 the Executive Director confirmed there was no evidence of a written plan for the PRN (as needed) administration of the Lorazepam in resident #2's medical record.	R167		
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure medications the home manages were stored in a locked compartment. Findings include: During the facility tour commencing at 9:07 AM on 6/19/23 an unattended unlocked refrigerator in a common area on the second floor of the home was observed to contain resident medications including eye drops, Acidophilus capsules; Bisacodyl suppositories; and insulin injector pens including Aspart, Levamir, and Lantus which were unsecured and accessible to residents, visitors, and undelegated staff. During the facility tour commencing at 9:07 AM	R173	**#5-- R173- Resident Care and Home Services** 1. The medication refrigerator was locked at time of discovery during survey. 2. Medication administration associates have been retrained by the HWD or nurse designee on the Medication and Treatment Storage policy as of 6/20/23. The HWD, ED, and Maintenance technicians will conduct daily rounds for 30 days and then routinely thereafter to verify compliance, as of 6/20/23 and ongoing. Tag R173 accepted on 7/27/2023 - S. Freeman	

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R173	Continued From page 6 on 6/19/23 the Director of Maintenance confirmed the unattended unlocked fridge on the second floor of the home contained medications which were unsecured and accessible.	R173		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there	R179	**#6--R179- Resident Care and Home Services** 1. The Business office manager is reviewing associates' records from January 1, 2023 until present for missing required yearly training. All associates who perform patient care will be up to date on yearly training by 8/15/23. 2. The business office manager will run an associate report monthly to verify yearly training is complete. 3. The ED will review the associate's yearly training report quarterly to verify compliance, beginning 8/15/23 and ongoing. Tag R179 accepted on 7/27/2023 - S. Freeman	

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R179	Continued From page 7 was a failure to ensure 2 out of 5 sampled staff completed all required yearly training. Findings include: Per review staff training records it was noted that 2 out of 5 staff that provide direct patient care did not complete all the required yearly training to include: resident rights, fire safety and emergency evacuation, resident emergency response procedures, such as the Heimlich maneuver, accidents, police, or ambulance contact and first aid, policies, and procedures regarding mandatory reports of abuse, neglect and exploitation, respectful and effective interaction with residents, general supervision, and care of residents. This was confirmed by the Administrator on 6/19/2023 at time of finding.	R179		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review there was a failure to ensure all perishable food items were dated and held at proper temperatures. Findings include: 1. During a tour of the facility commencing at 9:07 AM on 6/19/23 a reach in refrigerator in the main kitchen contained opened undated perishable	R247	**#7--R247 Nutrition and Food Service** 1. Opened and undated items were discarded at the time of discovery. 2. The dining service manager has retrained staff on food storage and labeling and dating policies as of 6/22/23. 3. The dining service manager or designee will monitor temp logs and opened perishable items in the refrigerator daily. The Executive Director will review temp log and conduct inspections of the kitchen refrigerators weekly for 4 weeks and then routinely to verify compliance, 6/20/23 and ongoing. Tag R247 accepted on 7/27/2023 - S. Freeman	

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R247	Continued From page 8 items including milk, soda, tomato juice, and multiple sundae toppings. The Director of Dining Services was present and confirmed these findings at the time of discovery. 2. The temperature of the Memory Center refrigerator was observed to be higher than 40 degrees during the facility tour commencing at 9:07 AM on 6/19/23 and on recheck at approximately 2:30 PM on 6/19/23. At 2:40 PM on 6/19/23 the Director of Dining Services confirmed the digital thermometer on the fridge door in the Memory Care Center indicated the fridge temperature was 42 degrees Fahrenheit. Per review of documented Memory Care Center fridge temperature checks, during the month of April 2023 the Memory Care Center fridge temps were above 40 degrees Fahrenheit 9 times, in May of 2023 the temps were above 40 degrees Fahrenheit 45 times, and as of 6/14/23 the fridge temps were above 40 degrees Fahrenheit 7 times in June of 2023. This finding was acknowledged by the Administrator on the afternoon of 6/19/23.	R247		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure a safe, functional, and	R266		

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R266	Continued From page 9 sanitary environment. Findings include: During the facility tour commencing at 9:07 AM on 6/19/23 the following observations were observed: 1. In the memory care center kitchenette the floor was observed to be sticky and soiled. The base of the wood trim around the doorway to the kitchenette was damaged and in need of painting. The Material Safety Data Sheets binder, which was stored in an open container attached to the side of the kitchen counter, was observed to be stained and coated with debris including dried food crumbs. These observations were acknowledged by the Executive Director on the afternoon of 6/19/23. 2. Oxygen was in use in Room #205, however signage indicating Oxygen was in use was not posted and visible. Per NFPA 101 Life Safety & NFPA 99 Health Care Facility Code, signage is needed when oxygen is in use. In addition, Lippincott Manual 8th addition Administering Oxygen by Nasal Cannula Procedure Guideline 10-14; page 244 states "Performance phase 1. Post NO SMOKING signs on the patient's door and in view of the patient and visitors" . During the tour commencing at 9:07 AM on 6/19/23 the Director of Maintenance confirmed signs indicating Oxygen was in use were not posted outside Room #205. 3. In the dining room of the home there was one missing window screen and one ripped window screen. This observation was acknowledged by the Executive Director on the afternoon of 6/19/23.	R266	**#8- R266- Physical Plant** 1. Kitchenette and MSDS binder were cleaned at time of survey. Oxygen and No smoking signs were posted for Room #205 at time of survey Window screen in dining room replaced on July 11, 2023. 2. Staff retrained on Fresh impressions policy as it relates to cleaning and sanitation common areas. 3. The dining room screen was replaced on 6/23/23, and the ripped screen was repaired on that day as well. 4. The maintenance technician or designee will conduct daily rounds to verify compliance. The Executive Director will conduct routine rounds to verify compliance, 7/31/23 and ongoing. Tag R266 accepted on 7/27/2023 - S. Freeman	

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R270	Continued From page 10	R270		
R270 SS=E	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.c Each bedroom shall have an outside window. (1) Windows shall be openable and screened except in construction containing approved mechanical air circulation and ventilation equipment. (2) Window shades, venetian blinds or curtains shall be provided to control natural light and offer privacy. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure window screens were in good repair in two resident rooms. Findings include: Per observation during the facility tour commencing at 9:07 AM on 6/19/2023 there were two ripped window screens in Room 315 and a patched window screen in Room 305. This observation was confirmed by the Director of Maintenance who conducted the facility tour.	R270	**#9--R270- Physical Plant** 1. Rooms #315 and #305 window screens were replaced on 6/23/23. 2. The maintenance technician will complete an audit of all windows to see if any other screens need to be repaired or replaced by 7/14/23. 3. The maintenance technician or designee will conduct daily rounds to verify compliance. The Executive Director will conduct routine rounds to verify compliance, 7/31/23 and ongoing. Tag R270 accepted on 7/27/2023 - S. Freeman	
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced	R291		

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R291	Continued From page 11 by: Based on observation and staff interview there was a failure to ensure water temperatures did not exceed 120 degrees Fahrenheit in resident areas of the residential care home (RCH). Findings include: Per observation on 6/19/23 at 9:40 AM water temperatures exceeded the required limit of 120 degrees Fahrenheit in two resident areas. Resident room #10 located on the RCH memory care unit water temperature was noted to be 123.8 degrees Fahrenheit, and resident room #11 water temperature was noted to be 121.6 degrees Fahrenheit. This observation was confirmed by the maintenance director at the time of findings. At 1:10 PM the maintenance director stated, "I have adjusted the water, but unfortunately the water has become hotter". After rechecking water temperatures resident room #10 was noted to be 125.6 degrees Fahrenheit, and resident room #11 was noted to be 124.9 degrees Fahrenheit. At 2:30 PM the maintenance director confirmed that the water temperatures exceeded the required 120 degrees and that there had been a broken part in the mixing valve that is now replaced.	R291	**#10-R291- Physical Plant** 1. The mixing valve was repaired by our plumber, and daily temperatures are being taken and recorded in a log in the Maintenance office. The Executive Director will monitor the temperature log to ensure compliance weekly. Tag R291 accepted on 7/27/2023 - S. Freeman	
R303 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.d There shall be an operable telephone on each floor of the home, at all times. A list of emergency telephone numbers shall be posted by each telephone.	R303		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: ______ B. WING ______	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

(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
R303	Continued From page 12 This REQUIREMENT is not met as evidenced by: The facility failed to ensure there was an operable telephone on the 3rd floor of the home, at all times with a list of emergency telephone numbers posted by each telephone. Findings include: During the course of the facility tour commencing at 9:08 AM on 6/19/23 there was no phone with emergency numbers posted on the 3rd floor. During the tour when this was identified, the maintenance director confirmed that there was no operable telephone with emergency numbers located on 3rd floor.	R303	**#11- R303 Physical Plant** 1. There is an operable telephone for resident use on each floor scheduled to be installed the week of 7/24/23. Emergency numbers will be posted where the telephones are located. 2. The maintenance technician will monitor these telephones weekly to confirm operational status. 3. The Executive Director will make routine rounds to verify compliance once installation complete, and ongoing. Tag R303 accepted on 7/27/2023 - S. Freeman	
R311 SS=E	X. PETS 10.2.e Pet health records shall be maintained by the home and made available to the public. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure that health records for all resident's pets were maintained by the home and available to the public. Findings include: During an interview on the afternoon of 6/19/2023 the Executive Director (ED) was requested to provide health records for the pets living in the Residential Care Home. The ED confirmed 1 dog and 2 cats were currently living in the home, and current health records for the 3 pets were not on file and available for review.	R311	**#12-R311 Pets** 1. Current health records of the pets residing at the community are now on file and are available for public review as of 7/15/23. 2. The business office manager will be responsible for collecting records on any new pets living in the community. 3. The Executive Director will review quarterly to verify compliance. Tag R311 accepted on 7/27/2023 - S. Freeman	
R999 SS=D	MISCELLANEOUS 4.13 (f) The residence shall make current written	R999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: ______ B. WING ______	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

(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
R999	Continued From page 13 reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The residence shall post a notice of the availability of all other written reports in a prominent place. If a copy is requested and the residence does not have a copy machine, the residence shall inform the resident or member of the public they may request a copy from the licensing agency and shall provide the address and telephone number of the licensing agency. Based on observation and staff interview there was a failure to ensure a current written report with results of inspection was readily available to residents. The residence shall make current written report results from inspection readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. Findings include: During a tour of the facility on 6/19/23 a copy of a current written inspection report was not posted and available to the public and residents. This was confirmed by the executive director on 6/19/23 at 11:05 AM stating "There used to be one in a binder, I am not sure what happened to it".	R999	**#13- R999- Miscellaneous** Current inspection reports were returned to the front lobby at the time of survey, 6/19/23. The business office manager will monitor the front lobby weekly to confirm current inspections reports are readily available. Tag R999 accepted on 7/27/2023 - S. Freeman	