VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

May 25, 2023

Mr. Travis Bergeron, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **May 1, 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
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475042	A. BUILDING ______ B. WING ______	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	**60 MAPLE LANE BARTON, VT 05822**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of two complaints and two facility reported incidents on April 25th, 2023 through May 1, 2023. The following regulatory deficiencies were identified:	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655	F 655 1. Residents #5 and #6 now have comprehensive care plans written which include interventions to prevent falls. 2. Residents admitted to the facility have the potential to be affected by the alleged deficient practice. 3. Education will be provided to the IDT members regarding the requirement for a baseline care plan to be completed within 48 hours of admission and include interventions needed to provide care that meet professional standards of care. 4. The Director of Nursing or designee will complete audits weekly to monitor effectiveness and compliance with the plan. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 6/15/2023. **Tag F 655 POC accepted on 5/25/23 by S. Stem/P. Cota**	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1	F 655		

this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident related to falls for 2 of 3 sampled residents (Residents #5 and #6). Findings include:

1. Record review reveals that Resident #5 was admitted to the facility on 4/19/2023 and has diagnoses that include: dementia, anxiety, hypertension, muscle weakness, and limitation of activities due to disability. A facility incident report reveals that Resident #5 had a fall on 4/21/2023. Review of Resident #5's baseline care plan reveals that it did not include any nursing interventions; specifically, it did not address safety or interventions to prevent falls. The only section of Resident #5's baseline care plan that was filled out was the Social Services section.

On 4/25/2023 at 1:25 PM, a Unit Coordinator confirmed that there were no nursing

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F 655	Continued From page 2 interventions in Resident #5's baseline care plan. 2. Record review reveals that Resident #6 was admitted to the facility on 4/7/2023 and has diagnoses that include: type 2 diabetes, heart failure, anxiety disorder, muscle weakness, and difficulty in walking. A facility incident report reveals that Resident #6 had a fall on 4/21/2023. Review of Resident #6's baseline care plan reveals that it did not address safety or include any interventions to prevent falls. On 4/25/2023 at approximately 5:00 PM, the Director of Nursing (DON) stated that all baseline care plans need to include interventions to prevent falls. On 4/26/2023 at 4:33 PM, the DON confirmed that Resident #5 and #6's baseline care plan did not include interventions to prevent falls.	F 655		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to implement interventions related to behaviors and provide adequate supervision to prevent accidents, injuries, and/or abuse for one applicable resident (Resident #1). Findings	F 689	F689 1. Identified residents have been reviewed for appropriate placement in the facility to allow for adequate supervision. 2. Residents residing on the unit have the potential to be affected by the alleged deficient practice. 3. The environment has been assessed and reviewed. Environment and staff assignments have been revised to allow for adequate supervision. 4. We will provide education to staff on preventing resident to resident altercations, adequate supervision and resident specific triggers.	

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F 689	Continued From page 3 include: Record review reveals that Resident #1 was admitted to the facility on 10/11/2022 and has diagnoses that include: dementia with agitation, hypothyroidism, cancer, heart disease, and need for assistance with personal care. A Physician admission note dated 10/13/2023 reveals that Resident #1 is "A 76 year-old [person] with myeloma and several comorbidities, including dementia with occasional aggressive behavior and history of falls, requiring constant supervision." Resident #1's care plan and notes also reveal that s/he has a history of trauma related to verbal, physical, and sexual abuse, and frequently wanders around the facility and into other residents' rooms. Resident #1's history of trauma related to abuse, aggressive behaviors, and frequent wandering, increases the potential for a resident-to-resident altercation and/or inappropriate touching between residents to occur. Resident #1's care plan includes the following focuses: [Resident #1] exhibits behaviors affecting others as evidence by wandering, entering other rooms, pushing/pulling others, pulling item, is aware this is not his home. Grabs staff arms/hands when has a need. Talks about the cops. Weepy spells, not wanting to be alone, likes hand held," created on 10/14/2022. Interventions include: "Monitor behaviors and record," created 10/14/2022; and "1:1 [one on one supervision] as needed," created on 11/28/2022. Elopement risk as evidenced by: [Resident #1] wanders aimlessly, has impaired safety awareness and is disoriented to place (nursing	F 689	5. DNS or designee will do weekly observational audits for 3 months to assess the effectiveness of the plan. 6. Results of the audit will be reported to the QAA committee for 3 months and then the committee will determine if further audits are required. 7. Corrective action date 6/15/2023. **Tag F 689 POC accepted on 5/25/23 by S. Stem/P. Cota**	

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home). This places [Resident #1] at significant risk of getting to a potentially dangerous place/stairs/outside the facility. Significantly intrudes on the privacy or activities of others," created on 10/14/2022. Interventions include: "Document all incidents of wandering," created on 10/14/2022.

Socially inappropriate and disruptive behavior as evidenced by touching other resident inappropriately," created on 3/26/2023. Interventions include: "Place patient/resident in area where observation is possible," created on 3/26/2023; and "Monitor wandering and redirect away from other rooms- stop strip [mesh barrier labeled stop that is placed across the door frame at waist height to deter others from walking in uninvited] on doors to remind [Resident #1] from wandering into other rooms," created on 3/26/2023.

Trauma as evidenced by reactions, statements like "they are going to kill you", "You will be raped", "You need to come with me right now or you will be raped", "You are going to be sorry when they find your body", physical signs of fear such as panic, and actual testimony from [Resident #1's spouse] relative to [Resident #1's] childhood," created on 12/10/2023. Interventions, created on 12/10/2022, include: "Staff will work to identify and eliminate the triggers that prompt [Resident #1's] flashbacks, panic, and fear," "Staff will participate in education relative to trauma informed care," and "Staff will observe and monitor [Resident #1 when] men are around as men were [his/her] physical and sexual abusers and those with similar characteristics to some of those abusers could be a trigger."

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F 689	Continued From page 5 1. Record review reveals that Resident #1 inappropriately touched Resident #3 on 3/5/2023. After this incident, Resident #1's aggressive behaviors and wandering increased. Notes show care plan interventions, such as supervision and redirection, were unable to be implemented or were not effective. Resident #1 inappropriately touched another resident (Resident #4) on 4/9/2023. A facility incident report dated 3/25/2023 reveals that Resident #1 was found sitting in Resident #3's bed massaging Resident #3's [body part]. A Licensed Nurse Assistant (LNA) statement reveals that this incident was discovered because the LNA was doing a floor check. A progress note dated 3/29/2023 reveals that Resident #1 was moved to the upstairs unit to be around other residents that are social. A 4/5/2023 progress notes states: "Pt [patient] was aggressive, angry, entering pt's room. Touching staff, tried to place hand into medication cart with nurse standing right in front of it. Pt is scaring [other] pt's as [s/he] enters the room and stares at them. This is constant problem through out the shift that worsens when aides are busy with pt care and not available to supervise pt." A 4/8/2023 progress note states: "Pt continues to wander, go into other pt.'s rooms, becomes hostile when redirected." A 4/9/2023 progress notes states: "Resident aggressive towards staff this AM and behaviors increased throughout the day. Resident approached other [resident] with clenched fists. Grabbed writers arm and attempted to grab	F 689		

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multiple LNAs. Very difficult to redirect. Wandering into other resident's rooms on both west and east wing."

A facility incident report reveals that on 4/9/2023, Resident #1 wandered into Resident #4's room. An LNA tried to redirect Resident #1 out of the room but was unsuccessful and Resident #1 was able to grab Resident #4's forearm and push/pull him/her down. The report reveals that Resident #4 had a 0.25 inch bruise on his/her forearm after the event. A statement from the above LNA reveals that Resident #1 "kept calling [Resident #4 his/her grandchild] and could not leave [him/her]" and the LNA had to call for help from a second LNA. A statement from the second LNA states that Resident #1 was grabbing Resident #4 tightly when they arrived and once they were about to get Resident #1 to release Resident #4 from his/her grasp, Resident #1 began swinging at both LNAs. A psychosocial assessment dated 3-29-2023 states: "It is important to note that [Resident #1] suffered acute verbal, physical, and sexual abuse as a child and young adult. [S/He] often had to save [his/her younger sibling] by grabbing [him/her] by the hand or arm and pulling [him/her] to a hiding place so [s/he] would not be raped by the men who came to the house. This could have been a triggered response." Of note, there were multiple male staff working in this area when this event occurred.

2. Observation and interviews reveal that Resident #1's care plan interventions are not effective in decreasing the risk of harm to himself/herself and others related to Resident #1's wandering and behaviors.

On 4/25/2023 at 12:01 PM, the Unit Coordinator

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F 689	Continued From page 7 stated that since Resident #1 moved upstairs his/her behaviors have increased. His/her wandering behaviors, especially going into other resident rooms require almost constant redirection most days. Per observation on 4/25/2023 at 1:51 PM, Resident #1 was alone with Resident #8 in a room at the end of the hall that could not be observed unless the observer was also at the end of the hall. This surveyor observed the two residents unsupervised for approximately two minutes in this room. On 4/25/2023 at 3:28 PM, an LNA stated that Resident #1 goes into other residents' rooms a lot. On 4/25/2023 at 3:35 PM, an Licensed Practical Nurse stated that stop strips are not always up. S/He will put them up if Resident #1 is displaying behaviors and if the residents in the room agree to have the stop strips up. S/He confirmed that they are not always up when Resident #1 is around. On 4/26/2023 at 12:58 PM, a Nursing Assistant stated that Resident #1 has become increasingly aggressive since s/he moved upstairs, probably because s/he is disoriented from the move. Resident #1 is always in other residents' rooms and has to be redirected and should have a one on one all the time. Someone needs to have eyes on him/her all the time, but there are not enough staff to do that. On 4/26/2023 at 1:08 PM, Resident #7 stated that s/he is afraid of Resident #1 because s/he sees how agitated s/he can be and how physical s/he	F 689		

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F 689	Continued From page 8 is with staff. Staff do try to keep an eye on him/her but sometimes s/he still gets into Resident #7's room. About 5 or so days ago Resident #1 was standing at the end of Resident #7's bed playing with his/her sheets in Resident #7's room while s/he was in the bed. Resident #7 reported that this was very scary. On 4/26/2023 at 4:33 PM, the Director of Nursing stated that staff are not documenting all of Resident #1's behaviors. His/Her increased behaviors are a combination of being on a new unit, working with new staff, and new medications. 3. The facility did not revise or implement Resident #1's trauma informed care plan. The care plan did not identify triggers or ways to mitigate or decrease the effect of triggers on the resident. F699 for additional information.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise and implement an individualized person-centered plan to render trauma informed care to a resident with a personal history of trauma related to abuse for	F 699	F 699 1. Resident #1 care plan has been updated to include known triggers and interventions. 2. Residents who reside in the facility who have experienced trauma have the potential to be affected by the alleged deficient practice. 3. Education will be provided to staff members regarding the requirement for trauma-informed care and receive care based on the resident's experiences and preference to eliminate or mitigate triggers that may cause re-traumatization to the resident.	

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F 699	Continued From page 9 one applicable resident (Resident #1). Findings include: Record review reveals that Resident #1 was admitted to the facility on 10/11/2022 and has diagnoses that include: dementia with agitation, hypothyroidism, cancer, heart disease, and need for assistance with person care. Per Resident #1's care plan and assessment notes, s/he has a history of trauma related to verbal, physical, and sexual abuse. Resident #1's care plan includes the following focus: "Trauma as evidenced by reactions, statements like "they are going to kill you", "You will be raped", "You need to come with me right now or you will be raped", "You are going to be sorry when they find your body", physical signs of fear such as panic, and actual testimony from [Resident #1's spouse] relative to [Resident #1's] childhood," created on 12/10/2023. Care plan interventions, created on 12/10/2022, include: Staff will work to identify and eliminate the triggers that prompt [Resident #1's] flashbacks, panic, and fear." Staff will participate in education relative to trauma informed care ..." Staff will listen to [Resident #1, their spouse, and his/her] children in order to gain understanding and learn how to prevent triggering and fear based upon family's knowledge of [Resident #1's] events and circumstances that brought [him/her] to where [s/he] is today." Staff will observe and monitor [Resident #1 when] men are around as men were [his/her] physical and sexual abusers and those with similar characteristics to some of those abusers could be a trigger." Staff will either stay with [Resident #1] or monitor	F 699	4. The Director of Nursing or designee will complete audits weekly to monitor effectiveness and compliance with the plan. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 6/15/2023. **Tag F 699 POC accepted on 5/25/23 by S. Stem/P. Cota**	

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F 699	Continued From page 10 [him/her] closely during times of triggered flashbacks and fear to return [him/her] to a sense of safety and calm." A psychosocial assessment dated 3-29-2023 states: "It is important to note that [Resident #1] suffered acute verbal, physical, and sexual abuse as a child and young adult. [S/HE] often had to save [his/her younger sibling] by grabbing [him/her] by the hand or arm and pulling [him/her] to a hiding place so [s/he] would not be raped by the men who came to the house. This could have been a triggered response." 1. Review of Resident #1's care plan reveals that the care plan was not revised to include trigger-specific interventions to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. No interventions were created related to the information revealed in Resident #1's 3/29/2023 psychosocial assessment. On 4/26/2023 at 3:50 PM, the Social Services Director stated that Resident #1's care plan for trauma informed care is effective depending on who is using it because not all the staff have the skills to use it. S/He confirmed that the care plan had not been revised since the interventions were created on 12/20/2023. On 5/1/2023 at 11:32 AM, the Director of Nursing stated that while the presence of men are sometimes a trigger for Resident #1, men are not always a trigger and if Resident #1 becomes triggered, there are interventions in other parts of Resident #1's care plan that staff can use. The	F 699		

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F 699	Continued From page 11 DON confirmed that the facility has not been able to identify what Resident #1's triggers are. 2. Interviews with staff reveal that all direct care staff working with Resident #1 are not aware that Resident #1 has a history of trauma or a care plan for trauma informed care. On 4/26/2023 at 12:58 PM, a Nursing Assistant stated that s/he was not aware that Resident #1 had a history of trauma or a care plan for trauma informed care. S/he stated that there should be interventions because Resident #1 can be very sexual with staff. On 4/26/2023 at 2:50 PM, a Licensed Nursing Assistant (LNA) stated that s/he was not aware that Resident #1 had a history of trauma or a care plan for trauma informed care. On 4/26/2023 at 3:45 PM, an LNA stated that s/he was not aware that Resident #1 had a history of trauma or a care plan for trauma informed care. 3. All facility staff working with Resident #1 did not have education related to trauma informed care. See F949 for additional information regarding the facility behavior health training.	F 699		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this	F 711	F711 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475042	A. BUILDING ____ B. WING ____	C 05/01/2023

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F 711	Continued From page 12 section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the physician wrote, signed, and dated progress notes with each visit as required for 3 of 3 sampled residents (Resident #1, #2, and #3). Findings include: Per record review of Resident #1, #2, and #3's electronic medical record and physical chart, there is no documentation of required physician visits from 1/1/2023 through 4/26/2023. On 4/26/2023 at 2:54 PM, Resident #1, #2, and #3's Attending Physician stated that s/he is behind on entering in progress notes and confirmed that s/he did not enter progress notes into electronic or physical charts for all resident visits. On 4/27/2023 at 2:09 PM, the Director of Nursing provided the following information: Resident #1's physician visits on 1/5/23, 2/26/2023, and 4/13/2023 were not entered into their record, signed, or dated until 4/27/2023. Resident #2's physician visits on 1/24/2023 and 3/16/2023 were not entered into their record, signed, or dated until 4/26/2023. Resident #3's physician visits on 2/2/2023 and	F 711	3. Facility administration, Attending MD, and Medical Director are aware of the requirement for physician notes to be signed and dated at each visit. 4. The Director of Nursing or designee will complete audits weekly to monitor effectiveness and compliance with the plan. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 6/15/2023. **Tag F 711 POC accepted on 5/25/23 by S. Stem/P. Cota**	

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F 711	Continued From page 13 3/23/2023 were not entered into their record, signed, or dated until 4/27/2023.	F 711		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility assessment, the facility failed to ensure that 6 of 6 sampled staff had effectively been trained in dementia and trauma informed care. Findings include: The facility's Facility Assessment [an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies], last updated 4/28/22, indicates that the facility is able to provide care and services for individuals with cognitive impairments, including dementia, and a history of trauma. "Part 2: Services and Care We Offer Based on our Residents' Needs ... Mental Status: Psychiatric Disorders and Behavior Management: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities."	F 949	F949 1. No residents were harmed from alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Facility administration is aware of the requirement for education for dementia and trauma informed care. 4. Staff will be educated in behavioral health with competencies. RN hired on 2/21/2023 left employment on 4/15/2023. 5. Education for all staff will be tracked. 6. The Director of Nursing or designee will complete audits weekly to monitor effectiveness and compliance with the plan. 7. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 8. Corrective action will be completed by 6/15/2023. **Tag F 949 POC accepted on 5/25/23 by S. Stem/P. Cota**	

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F 949	Continued From page 14 Review of 6 direct care staff education records reveal the following staff did not have documentation of a behavior health training course that includes the competencies and skills necessary to provide care for individuals with a history of trauma or diagnosis of dementia: LNA #1, hired 1/16/23; LNA #2, hired 3/20/23; LPN #1, hired 2/20/23; LNA #3, hired 2/13/23; RN #1, hired 2/21/23; and LNA #4, hired 1/16/23. On 4/26/2023 at 2:50 PM, an LNA stated that s/he did not do dementia or trauma training at this facility. On 4/26/2023 at 2:10 PM, the Director of Nursing (DON) stated that the facility is in the process of changing the training program, but right now multiple staff help with staff education and tracking the training. At 3:20 PM, the DON confirmed that there was no evidence that sampled staff had dementia or trauma training.	F 949		