STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	11/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 11/05/18 and concluded 11/07/18.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		12/10/18

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

Electronically Signed | 11/23/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide dignity and respect during resident dining in 1 of 2 resident dining rooms (secured memory unit). Failure to wait until the residents have left the table before removing the dishes and sanitizing the tables does not preserve the residents' dignity or enhance their quality of life. Findings include: Observation on 11/05/18 at 11:46 a.m. showed 10 residents in the secured memory unit dining room eating the noon meal. An unidentified staff member stood in the dining room with a wheeled cart utilized for dirty dishes, left-over food, a bucket of soapy water, and a bucket of sanitizing solution. As soon as a resident, seated at a table with other residents, finished eating, the staff member pushed the cart to the table, removed the dishes, scraped left over food into a bucket, and washed/sanitized the table area while all the residents were still eating. The staff member continued this process until all the residents finished eating. During an interview on 11/05/18 at 1:15 p.m., an administrative nurse (#1) stated facility staff	F 550	F550 – Resident Rights/Exercise Rights 1. Staff will be educated on not cleaning tables until all residents at that table have finished eating. Education was provided to staff who were working at the time of the table cleaning on 11/5/18. 2. All residents who eat in a facility dining room have the potential to be affected. 3. Education will be provided to staff on the process of cleaning tables to not impact the resident's rights by 11/30/18. The facility will ensure tables are cleaned in an appropriate manner. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on 12/1/18. The DON or designee will be responsible for monitoring table cleaning for ten meals weekly for one month, ten meals monthly for 3 months, and then audits will be completed at least quarterly for 1 year with additional audits as recommended by the QA committee. Results will be	

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F 550	Continued From page 2 should clean the dining tables after all the residents have left the table.	F 550	reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: 12/10/18	
F 689 SS=D	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, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 9 sampled residents (Resident #36 and #253) observed during gait belt transfers. Failure to properly use a gaitbelt and to ensure adequate assistance during gaitbelt transfers placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "Standards of Care" occurred on 11/07/18. This policy, revised December 2016, stated, ". . . A gait belt will be used for assisted transfers and ambulation . . ."	F 689	F689 – Free of Accident Hazards/Supervision/Devices 1. Staff will be educated on the appropriate placement of a gait belt for Resident #36. Resident #253 no longer resides in the facility. Education was provided to staff who were working at the time of the incidents on 11/5/18 and 11/6/18. 2. All residents who require assistance with transfers that utilize a gait belt have the potential to be affected. All nursing staff will be checked for competency. 3. Nursing education will include	12/10/18

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F 689	Continued From page 3 Berman, Snyder, and Fandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, "10th edition, Pearson Education, INC, New Jersey, page 1054, stated, "use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." - Review of Resident #36's medical record occurred on all days of the survey. A quarterly Minimum Data Set (MDS), dated 09/05/18, identified the resident required extensive assist of two for transfers. The resident's current care plan stated, ". . . Transfers: Assist of 2 . . ." During an observation on 11/06/18 at 4:54 p.m., two certified nursing assistants (CNA) (#2 and #4) transferred Resident #36 from the wheel chair to the toilet with a gaitbelt. During the transfer, the gait belt slid up the resident's back and the CNAs failed to adjusted or tightened it. The CNAs (#2 and #4) then transferred Resident #36 from the toilet to the wheel chair. One CNA (#2) held under the resident's axilla and not to the gait belt and the other CNA (#4) held onto the gait belt. The CNAs failed to readjust or tighten the gaitbelt prior to the transfer and it slid up the residents back. During the transfer, observation showed Resident #36 unsteady. - Review of Resident # 253's medical record occurred on all days of the survey. The current care plan stated, ". . . Transfers: assist of 2 . . ." During an observation on 11/05/18 at 2:35 p.m.,	F 689	appropriate use and positioning of gait belts. The facility will ensure gait belts are positioned and utilized appropriately for residents that use them during transfers. Staff education will be provided by 11/30/18. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on 12/1/18. The DON or designee will be responsible for monitoring proper gait belt use and positioning for ten residents weekly for one month, ten residents monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: 12/10/18	

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F 689	Continued From page 4 two CNA's (#3 and #5) transferred Resident #253 from the recliner to the wheelchair with a gait belt. The CNAs held onto the gait belt with one hand and under the resident's axilla with the other. Observation showed the loose gait belt slid up the residents back. The CNAs then transferred the resident from the toilet to the wheel chair. During the transfer, one CNA (#5) held under both the resident's axillae, and the other CNA (#3) held the wheel chair in place. The CNA's (#3 and #5) failed to use the gait belt or assist with the transfer. During an interview on 11/07/18 at 11:08 a.m., an administrative staff nurse (#1) stated the facility does not have a specific policy for how to use a gait belt. The administrative staff nurse (#1) stated the facility provided annual training on proper use of a gait belt and had standards of care signed by new hires and reviewed annually.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide treatment and services in a manner to maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #71) observed experiencing pain during cares. Failure of staff to report,	F 697	F697 – Pain Management 1. Staff will be educated on the proper protocol to ensure resident's pain is managed. Resident #71 was assessed for pain and interventions implemented.	12/10/18

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F 697	Continued From page 5 document, and act on Resident #71's pain placed the resident at risk for continued pain and worsening health conditions. Findings include: During an interview on 11/05/18 at 10:25 a.m., Resident #71's family member stated the resident recently fell and needed sutures above his eye and hurt his knee during another fall. The family member stated, "[Resident #71] seems to have a lot of pain with movement now." Review of Resident #71's medical record occurred on all days of survey. Diagnoses included a history of falls and fractures. Pain medications included Tylenol 325 milligrams, 2 tablets as needed for pain or fever. The current care plan stated, "I have acute pain r/t [related to] Fracture . . . Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. *Inform caregivers to report to the nurse any s/sx [signs/symptoms] of non-verbal pain: . . . Vocalizations (grunting, moans, yelling out, silence); . . . Body (tense, rigid, rocking, curled up, thrashing. . . ." Resident #71's progress notes identified the following unwitnessed falls: * 10/09/18 at 11:05 p.m. - Required five sutures above the eye * 10/11/18 at 12:00 a.m. - Abrasion to the right knee (later treated for an infection) - Observation on 11/6/18 at 8:00 a.m. showed Resident #71 in bed and positioned on his back. The nurse (#6) and a certified nursing assistant	F 697	Education was provide to staff who were working at the time of the observations on 11/6/18. 2. All residents have the potential to be in pain and be affected. 3. Nursing staff will be educated on the signs and symptoms of pain, process on reporting resident's pain, and interventions to treat pain. Staff education will be provided by 11/30/18. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on 12/1/18. The DON or designee will be responsible for monitoring resident's pain for ten residents weekly for one month, ten residents monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: 12/10/18	

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F 697	Continued From page 6 (CNA) (#7) rolled the resident side to side while checking his brief, and then positioned him on his right side. Observation showed Resident #71 moaned during the care and the CNA (#7) stated, "He has pain with any movement." - Observation on 11/6/18 at 10:45 a.m. showed Resident #71 moaned as the CNA (#7) repositioned him. The CNA stated, "He has pain with any movement so we're so careful." - Observation on 11/6/18 at 2:10 p.m. showed Resident #71 moaned as the nurse (#6) and two CNAs (#8 and #9) checked and changed his brief and repositioned him. The CNA (#8) stated to the resident, "I know every movement hurts." Review of Resident #71's medication administration record (MAR), dated October 01, 2018 through November 07, 2018 showed a nursing staff administered Tylenol once on 11/5/18 at 11:11 a.m. for a fever. The facility failed to report, document, and treat Resident #71's pain even after staff acknowledged he experienced pain during cares.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/10/18

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F 761	Continued From page 7 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: MEDICATION LABELING 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications for 2 of 8 residents (#8, and #80) observed during medication pass. Failure to correctly label medications increases the risk of residents receiving an inaccurate dose and/or medication. Findings include: Review of the facility policy titled "Medication administration Information" occurred on 11/07/18. This policy, revised October 2016, stated, ". . . labeling of the medications will be according to accepted pharmacy standards . . ." - Observation on 11/05/18 at 10:51 a.m. showed a staff nurse (#19) administered 7 units of	F 761	F761 – Label/Store Drugs and Biologicals 1. Staff will be educated on proper process of labeling medications when changes of physician orders occur and not storing food or beverages in the medication refrigerator. Education was provide to staff who were working during the observations on 11/5/18 and 11/6/18. 2. All residents have the potential to be affected by improper medication labeling and medication storage practice. 3. Nursing staff will be educated on the proper process of labeling medications when the physician order changes and not storing food or beverage in the medication refrigerators. Will collaborate	

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F 761	Continued From page 8 Novolog 70/30 insulin to Resident #8. The label on the insulin vial identified a dose of Novolog 70/30 inject 8 units subcutaneously two times a day. A physician's order identified Novolog 70/30 insulin 7 units twice daily. Review of Resident #8's orders showed the physician changed the Novolog 70/30 order from 8 units to 7 units on 10/19/18, 18 days prior to the 11/05/18 observation. - Observation of the medication pass on 11/06/18 at 8:38 a.m. with a medication assistant (MA) (#16) identified a bottle of oral Morphine for Resident #80. The label on the box showed a red sticker over the current label that identified a change in dose and to check the chart for the correct dosage. Resident #80's physician's orders identified the new dose of Morphine was started on 10/22/18, but no new label had been placed on the bottle. Staff failed to obtain a new label from pharmacy for the morphine with the current physician orders. During an interview on the afternoon of 11/08/18, an administrative nurse (#1) stated she expected the facility to follow the medication administration policy. MEDICATION STORAGE 2. Based on observation, review of facility policy, and staff interview, the facility failed to provide for safe medication storage in 1 of 3 medication refrigerators (Unit C) observed during the medication room inspection. Failure to provide a	F 761	with local pharmacies to ensure medications for changes in physician orders are properly labeled. Staff education will be provided by 11/30/18. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on 12/1/18. The DON or designee will be responsible for monitoring medication labeling and refrigerated medication storage areas. Medication labeling will be audited for ten residents weekly for one month, ten residents monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Refrigerated medication storage areas will the audited ten observations per week for a month, ten observations monthly for three months and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: 12/10/18	

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F 761	Continued From page 9 clean environment for refrigerated medications may result in medication contamination. Review of the facility policy titled, "Refrigerator-Medication Temperature Checks" occurred on 11/7/18. This policy revised December 2017 stated, ". . . no food or beverages are allowed in the medication refrigerator . . ." Observation on 11/06/18 at 5:45 p.m. showed the Unit C medication refrigerator contained medications along with warm food. A certified nurse aide (CNA) (#20) identified the food tray as his/her dinner tray. During an interview on 11/07/18 at 2:11 p.m., an administrative nurse (#1) stated the facility policy prohibited food or beverages in the medication refrigerator and the policy needs to be followed.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,	F 880		12/10/18

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F 880	Continued From page 10 identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: GLOVE USE AND HAND HYGIENE 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices in 1 of 1 soiled laundry sorting room. Failure to follow infection control practices related to glove use and hand hygiene while handling soiled laundry has the potential to spread infection to residents, staff members, and visitors. Findings include: Review of the facility policy titled "Handling of Soiled Linen" occurred on 11/07/18. This policy, revised April 2017, stated, "Policy: It is the policy of Eventide to practice universal/standard precautions when handling soiled linen. Purpose: To avoid cross contamination. Procedure: 1. Use appropriate PPE [personal protective equipment]. . . ." Review of the facility policy titled "Hand Hygiene" occurred on 11/07/18. This policy, revised	F 880	F880 – Infection Prevention & Control 1. Staff will be educated on proper infection control process with glove use in the soiled laundry room, appropriate sanitizing solution levels, and disinfecting mechanical lifts. Education was provided to staff who were working during the observations 11/5/18, 11/6/19 and 11/7/18. 2. All residents have the potential to be affected by improper infection control practices. 3. Facility staff will be educated on the proper infection control process for glove use in the soiled laundry room, appropriate sanitizing solution levels, and disinfecting mechanical lifts. Staff education will be provided by 11/30/18. 4. QA monitoring will be implemented following completion of mandatory	

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	355078	A. BUILDING _____ B. WING _____	11/07/2018

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F 880	Continued From page 12 November 2013, stated, "Policy: . . . Hand hygiene will be done . . . after every dirty procedure . . ." A tour of the laundry service department occurred on 11/07/18 at 10:45 a.m. with an administrative staff member (#11). Observation showed two certified nursing assistants (CNAs) (#10 and an unidentified CNA) in the soiled laundry/utility room sorting soiled linen and one CNA (#10) failed to wear gloves. When questioned, the CNA (#10) stated she forgot and then donned gloves. When the CNA (#10) finished sorting the soiled linen, she removed her gloves and exited the room. The CNA failed to perform hand hygiene after removing gloves and before exiting the room. During an interview on 1/07/18 at 10:50 a.m., the administrative staff member (#11) stated he/she expected staff members to wear gloves when sorting soiled laundry. SANITIZING SOLUTION 2. Based on observation and staff interview, the facility failed to ensure appropriate sanitization in food serving areas in 1 of 2 resident dining rooms (secured memory care unit). Failure to ensure quaternary (chemical used to sanitize) solutions remained at a proper concentration level to sanitize may result in inadequate sanitization and placed residents at risk for foodborne illness. Findings include: Observation on 11/06/18 at 9:35 a.m. showed two staff members (#6 and #9) cleaned the	F 880	education. QA will be initiated on 12/1/18. The DON or designee will be responsible for monitoring the proper infection control practices related to glove use in the soiled laundry room, appropriate sanitizing solution levels and disinfecting mechanical lifts. Glove use in the soiled laundry room will be audited ten times weekly for one month, ten times monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Appropriate sanitizing solution levels will be audited ten times weekly for one month, ten times monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. The disinfecting of mechanical lifts will be audited ten times weekly for one month, ten times monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: 12/10/18	

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F 880	Continued From page 13	F 880		

dining tables in the secured memory care unit. One bucket contained soapy water for cleaning and the other bucket contained a sanitizing solution for disinfecting. The staff member (#6) stated the bucket containing sanitizer came from the dietary department about 6:30 a.m. with the morning meal.

Observation at 9:44 a.m. showed a dietary staff member (#12) entered the unit and checked the sanitation concentration in the bucket with a quaternary test strip. The concentration measured "0." A zero reading would indicate no surface sanitizing was completed.

During an interview at this time, the dietary staff member (#12) stated she expected the quaternary solution to measure between 200-400 parts per million (ppm).

DISINFECTION OF EQUIPMENT

3. Based on observation, review of the facility education checklist, and staff interview, the facility failed to ensure staff followed appropriate infection control practices related to disinfecting equipment for 5 of 13 residents (Residents #6, #22, #44, #88, and #99) transferred with mechanical lifts. Failure to follow appropriate infection control practices has the potential for the transmission of communicable diseases and infections to residents and staff.

Findings include:

Review of the facility checklist titled "EZ way hoyer lifts" occurred on 11/07/18. This checklist stated, ". . . 12. Remove the sling . . . 13. Wipe

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F 880	Continued From page 14 down the machine . . ." - Observation on 11/05/18 at 10:30 a.m. showed a CNA (#13) utilized a sit-to-stand mechanical lift to transfer Resident #99 from a wheelchair to the toilet, and then back to the wheelchair. The CNA failed to disinfect the mechanical lift after resident use. - Observation on 11/05/18 at 4:00 p.m. showed a CNA (#13) utilized a sit-to-stand mechanical lift to transfer Resident #6 from a wheelchair to the toilet, and then back to the wheelchair. The CNA failed to disinfect the mechanical lift after resident use. - Observation on 11/06/18 at 8:49 a.m. showed a CNA (#14) utilized a sit-to-stand mechanical lift to transfer Resident #99 from a wheelchair to the toilet, and then to the bed. The CNA failed to disinfect the mechanical lift after resident use. - Observation on 11/06/18 at 9:16 a.m. showed a CNA (#17) utilized a full body mechanical lift to transfer Resident #44 from a wheelchair to the bed. The CNA failed to disinfect the mechanical lift after resident use and immediately wheeled it into another residents room. - Observation on 11/06/18 at 9:35 a.m. showed a CNA (#18) utilized a sit-to-stand mechanical lift to transfer Resident #22 from a wheelchair to the toilet, and back to the wheelchair. The CNA failed to disinfect the mechanical lift after resident use and before storage of the lift. - Observation on 11/06/18 at 10:40 a.m. showed a CNA (#15) utilized a sit-to-stand mechanical lift	F 880		

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F 880	Continued From page 15 to transfer Resident #88 from a wheelchair to the toilet, and then back to the wheelchair. The CNA failed to disinfect the mechanical lift after resident use. During an interview on the afternoon of 11/07/18, an administrative nurse (#1) stated staff are expected to wipe down all lifts after each resident use.	F 880		