Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265852900M
Compliance #: HL265852660C

Date Concluded: June 28, 2024

Name, Address, and County of Licensee Investigated:
Edgewood Sartell LLC
677 Brianna Drive
Sartell, MN 56377
Stearns County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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 the resident when staff failed to ensure food was prepared and served per Minnesota Food Code. The resident was served undercooked pork and became sick with a foodborne illness. In addition, the facility failed to ensure services were provided according to the resident's care plan and failed to check on the resident for six hours. The resident was found on the floor, covered in secretions and vomit, and cold to the touch. The resident was admitted to the hospital where he later died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident's death certificate listed his cause of death as acute infectious gastroenteritis (inflammation of the stomach and intestines causing diarrhea, vomiting, and nausea) due to yersinia enterocolitica (a bacteria most often acquired by handling or eating raw or undercooked pork). However, it is unable to be determined where or how the resident acquired the bacteria. Menus reviewed indicated that pork was served by the facility days prior to the resident's

hospitalization, but there was no evidence that other residents experienced similar symptoms. The facility was found to have deficient practices related to food handling and food preparation. In addition, it was identified that the resident was likely on the floor for several hours; however, the resident's service plan did not include overnight safety checks. The resident also had a call light pendant, but the pendant was not within reach at the time of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement and the ambulance service. The investigation included review of resident records, a death record, hospital records, facility incident reports, staff schedules, menus and food preparation logs, the law enforcement report, ambulance report, and related facility policies and procedures. Also, the investigator observed meal service and kitchens in use at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure) and abnormal weight loss. The resident's service plan included assistance with dressing, showers, escorts to meals, and medication administration. The resident's assessment indicated the resident was independent with most activities of daily living.

The resident's medical record indicated staff found the resident lying in front of his recliner with an area of dried emesis (vomit) around his mouth. The resident reported to staff that he went to the bathroom and could not remember how he got onto the floor but believed he had been lying there for most of the night. Staff noted that the resident's walker and call pendant were left in the bathroom and the resident reported hitting his head. Staff contacted emergency medical services (EMS) and the resident was sent to the hospital for further evaluation.

The ambulance report indicated the resident had loose stools and vomiting on and off for the past day. The report indicated the resident tried to get out of his recliner but was too weak to stand and fell. The resident reported to ambulance staff that he had been on the floor for about eight hours.

The police report indicated the resident was observed laying on his stomach on the living room floor between the couch and the recliner and noted that the resident vomited and was incontinent of bowel.

Hospital records indicated the resident was found covered in vomit and feces and there was a reported outbreak of viral gastroenteritis at the facility. The resident's admitting diagnoses included septic shock (a medical emergency caused by a systemic response to infection) and acute infectious gastroenteritis due to yersinia enterocolitica.

The resident died 12 days after admission to the hospital. The resident's death record indicated the immediate cause of death was septic shock due to acute infectious gastroenteritis due to

yersinia enterocolitica and acute septic/metabolic encephalopathy (damage or disease that affects the brain) with severe dysphagia (difficulty swallowing).

A review of the facility's menu from the days leading up to the resident's hospitalization, indicated pork was served on several different days. The facility did not consistently maintain temperature logs to record the temperature of food before it was served. At the time of the onsite visit, the investigator observed deficient practices related to food storage and food handling. The facility was informed that the resident was admitted to the hospital with a foodborne illness; however, the facility failed to communicate this information to the dietary department. The facility failed to take action to investigate if the foodborne illness originated from their facility or if mitigating action as required.

During an interview, an administrative nurse stated that the facility did not receive many updates from the hospital but recalled she was told the resident had "a rare something" caused from undercooked pork but no other residents displayed similar symptoms. The nurse stated that the resident's family took him out of the facility a lot so he could have eaten something somewhere else.

During an interview, dietary management staff stated they were not aware the resident was hospitalized with a foodborne illness but indicated that should have been communicated to the dietary department to determine if there was any follow-up required.

During an interview, facility management staff stated they found out about the resident's death shortly after he passed away. Management staff stated it was at that time they found out the resident passed away due to a foodborne illness. Management staff stated that the hospital never contacted the facility about this, but they later received a concern that the resident had eaten bad pork or bad meat. Management staff stated they reviewed the menu and saw pork was served but indicated that all pork products came to the facility pre-cooked. Management staff acknowledged the dietary department was not informed of the resident's diagnosis as they didn't consider this foodborne illness related because they weren't informed by the hospital right away.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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 was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

Action taken by the Minnesota Department of Health:
Insert appropriate action from standard language document

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

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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: #HL265852900M/#HL265852660C On April 29, 2024, 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 85 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL265852900M/#HL265852660C, tag identification 0480, 0620, 2320.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to ensure food was labeled as required under 4626.0400 DATE MARKING; READY-TO-EAT TCS (time/temperature control for safety) FOOD. 3-501.17 which includes that refrigerated, ready-to-eat TCS food prepared and held in a food establishment for more than 24 hours must be clearly marked using an effective method to indicate the day or date by which the food must be consumed on the premises, sold, or	0 480		

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0 480	Continued From page 2 discarded, which is 7 calendar days or less from the date of preparation. The date of the preparation must be counted as day one. On April 29, 2024, at 9:55 a.m., the following observations were made and confirmed by dining services director (DSD)-B in the assisted living kitchen: -The fridge in the assisted living kitchen contained a container of raw pork labeled with a use by date of March 22nd. DSD-B stated, "I bet they meant to write 4/22." DSD-B confirmed even if the date was meant to be 4/22, it was past the time frame for raw meat to be stored in the refrigerator. -Also in the refrigerator was an unlabeled, undated container of hard boiled eggs and a three quart container labeled "Meat" with a use by date of April 24. Various other items were observed to have dates written on the "use by date" line but contained no preparation date and items were inconsistently labeled. DSD-B stated that staff should write a date on the use by date, that was not the date it needed to be used by but was the date the food was put in the fridge. DSD-B stated most food should be used within seven days, but things like eggs should be used within three days. DSD-B was asked if things were labeled and stored per protocol. DSD-B stated, "You can see it's not labeled, I can see it's not labeled. I'm not going to argue with you on that." -A 6 quart container filled to the top with sticks of butter was observed sitting on a preparation table in the kitchen. The container lacked a date or any kind of identifying label. On April 29, 2024, at 10:05 a.m., the following observations were made and confirmed by DSD-B in the memory care kitchen:	0 480		

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0 480	Continued From page 3 -The fridge in the memory care kitchen contained an open container of lemon juice with the date 9/22 written on the cap. -The dry goods storage contained a 6 quart container filled to the top with sticks of butter. The container lacked a date or any kind of identifying label. -On another shelf of the cooler was a container labeled "riblets in gravy" with a use by date of April 21. Nearby was an unlabeled, undated, container of hard boiled eggs. On April 29, 2024, at 11:00 a.m., scones were observed near a coffee station in the assisted living dining room. The scones were labeled with a use by date of April 28. The licensee's Dining Services Policy and Procedure Manual dated November, 2012, indicated At the time of receiving, all food should be placed in proper storage. Use FIFO (First In, First Out) method of storage so that the older supplies are used first. If possible, store items in their original containers or sealed in tightly covered NSF containers that are dated and labeled. On each package that is removed from its original container, write when the item was received, or when it was stored after preparation. Clean up all spills and leaks and remove dirty packaging and trash immediately. Cleaning supplies and chemicals must be stored away from food preparation and storage areas. Do not store any items on the floor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 480		

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0 620	Continued From page 4	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 5 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who was hospitalized with a foodborne illness. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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).	0 620		

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0 620	Continued From page 6 The findings include: R1's diagnoses included hypertension (high blood pressure) and abnormal weight loss. R1's service plan dated January 25, 2023, indicated the resident received assistance with dressing, showers, escorts to meals, and medication administration. R1's most recent assessment dated October 27, 2023, indicated the resident was independent with most activities of daily living. R1's progress notes indicated the resident was seen by his primary care provider on December 11, 2023, with no new orders written. A progress note from December 15, 2023, indicated the resident was "found lying face down in front of his recliner. Resident did not have pants on and there was dried BM [bowel movement] on both legs. There was a small area of dried emesis next to his mouth....Resident reported he went to the bathroom d/t [due to] loose stools and could not remember how he got onto the floor in the living room. Resident believed he was lying there for most of the night. Walker and call pendant were left in the bathroom by resident. He did report hitting his head..." The ambulance report dated December 15, 2023, indicated the resident had been having loose stools and vomiting on and off for the past day. The report indicated the resident tried to get out of a recliner but was too weak to stand and fell. The resident reported to ambulance staff that he had been on the floor for about eight hours. The police report dated December 15, 2023, indicated the responding officer observed the	0 620		

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0 620	Continued From page 7 resident laying on his stomach on the living room floor between his couch and recliner. The resident "had vomited while laying on the floor and had diarrhea on the recliner and down his legs..." Hospital records indicated the resident "presented from assisted living after being found covered in vomit and stools on December 15, 2023. There is a reported outbreak of viral gastroenteritis at the facility." The resident's admitting diagnoses included septic shock and acute infectious gastroenteritis due to Yersinia enterocolitica (an infection that can be caused by raw or undercooked pork). R1's death record indicated the resident died on December 28, 2023. The immediate cause of death was septic shock due to acute infectious gastroenteritis due to yersinia enterocolitica and acute septic/metabolic encephalopathy, severe with severe dysphagia. On April 29, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated the facility did not get many updates from the hospital but she was told "something about how he had a rare something that was caused from undercooked pork, but we didn't have any other residents with that [symptoms] and his son took him out a lot so I don't know if he could have eaten something somewhere else." CNS-A was asked if the facility had initiated an internal investigation since the resident was being treated for a foodborne illness and stated, "I can't recall, the kitchen's not really my forte." CNS-A stated they hadn't considered filing a MAARC report because "the son told us the hospital already did. I had no paper records of foodborne illness it was only heresay."	0 620		

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0 620	Continued From page 8 On April 29, 2024, at 11:10 a.m., dining services director (DSD)-B stated she was not aware R1 was hospitalized with a foodborne illness but that would be something that should be communicated to the dietary department to determine if any follow up was needed. On April 30, 2024, at 9:05 a.m., licensed assisted living director (LALD)-C stated he found out about the resident's death shortly after Christmas and that CNS-A had looked into it and "I think that's when we found out he passed away due to some foodborne illness...We were never contacted by the hospital and shortly after that a son reached out to us about a concern for his dad and they believed he had eaten bad pork or bad meat." LALD-C stated "someone from I think it was the Department of Health reached out and we supplied our menu from the week before and some temp logs and visitor logs." The investigator advised LALD-C no one from this office had reached out requesting information so it could have been an infectious disease related department. LALD-C stated they didn't do a MAARC report for the foodborne illness because "we weren't notified. I guess I would have thought they [the hospital] would have done that and we didn't hear any more back from the hospital." LALD-C stated they looked at the menu and saw it did have pork but "that all comes to us pre cooked." LALD-C stated they would typically talk to the leadership team if issues came up but also wouldn't share certain things due to "patient confidentiality." LALD-C stated, "I think the difference is we didn't see it as a foodborne illness because we didn't hear from the hospital right away." LALD-C stated the issue would have been considered a reportable event as staff had been made aware of the diagnosis.	0 620		

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0 620	Continued From page 9 The licensee's Abuse Prevention, Intervention, Reporting, and Investigation policy dated March 2024, indicated It is the responsibility of employees to promptly report concerns to Executive Director (or designee) and Clinical Services any incident or suspected incident of neglect or resident abuse from other residents, staff, family or visitors including injuries of an unknown source and theft or misappropriation of resident property. All reports of resident verbal, sexual, physical and mental abuse; exploitation; involuntary seclusions; neglect; or misappropriation of resident property are promptly and thoroughly investigated by Community management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when staff failed to investigate a suspected reported foodborne illness for one of	02320		

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02320	Continued From page 10 one resident (R1) reviewed. The licensee was aware R1 was admitted to the hospital and diagnosed with Yersinia enterocolitica (an infection that can be caused by raw or undercooked pork). The licensee failed to notify its dining services department or investigate if the foodborne illness was a result of practices in the facility. The resident later died in the hospital. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or 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 hypertension (high blood pressure) and abnormal weight loss. R1's service plan dated January 25, 2023, indicated the resident received assistance with dressing, showers, escorts to meals, and medication administration. R1's assessment dated October 27, 2023, indicated the resident was independent with most activities of daily living. R1's progress notes indicated the resident was seen by his primary care provider on December 11, 2023, with no new orders written. R1's progress note from December 15, 2023, indicated the resident was "found lying face down in front of his recliner. Resident did not have	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	C 04/29/2024

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02320	Continued From page 11 pants on and there was dried BM [bowel movement] on both legs. There was a small area of dried emesis next to his mouth....Resident reported he went to the bathroom d/t [due to] loose stools and could not remember how he got onto the floor in the living room. Resident believed he was lying there for most of the night. Walker and call pendant were left in the bathroom by resident. He did report hitting his head..." The ambulance report dated December 15, 2023, indicated R1 had been having loose stools and vomiting on and off for the past day. The report indicated the resident tried to get out of a recliner but was too weak to stand and fell. R1 reported to ambulance staff that he had been on the floor for about eight hours. The police report dated December 15, 2023, indicated the responding officer observed the R1 laying on his stomach on the living room floor between his couch and recliner. The resident "had vomited while laying on the floor and had diarrhea on the recliner and down his legs..." Hospital records indicated R1 "presented from assisted living after being found covered in vomit and stools on December 15, 2023. There is a reported outbreak of viral gastroenteritis at the facility." R1's admitting diagnoses included septic shock and acute infectious gastroenteritis due to Yersinia enterocolitica. R1's death record indicated the resident died on December 28, 2023. The immediate cause of death was septic shock due to acute infectious gastroenteritis due to yersinia enterocolitica and acute septic/metabolic encephalopathy, severe with severe dysphagia.	02320		

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02320	Continued From page 12 Review of the facility's December 2023 menus indicated pork was served in the days prior to R1's hospitalization. Review of kitchen documentation indicated that the facility did not consistently maintain temperature logs to record the temperature of food before it was served. Facility documentation included no record of a viral outbreak of gastroenteritis the week of December 2023, although R1's hospital records indicated a reported an outbreak at the facility at the time of R1's hospitalization. On April 29, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated the facility did not get many updates from the hospital but she was told "something about how he [R1] had a rare something that was caused from undercooked pork, but we didn't have any other residents with that [symptoms] and his son took him out a lot so I don't know if he could have eaten something somewhere else." CNS-A was asked if the facility had initiated an internal investigation since the resident was being treated for a foodborne illness and stated, "I can't recall, the kitchen's not really my forte." On April 29, 2024, at 11:10 a.m., dining services director (DSD)-B stated she was not aware R1 was hospitalized with a foodborne illness but stated that should be communicated to the dietary department to determine if any follow up was needed. On April 30, 2024, at 9:05 a.m., licensed assisted living director (LALD)-C stated he found out about the resident's death shortly after Christmas and that CNS-A had looked into it and "I think that's when we found out he passed away due to some foodborne illness...We were never contacted by	02320		

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02320	Continued From page 13 the hospital and shortly after that a son reached out to us about a concern for his dad and they believed he had eaten bad pork or bad meat." LALD-C stated "someone from I think it was the Department of Health reached out and we supplied our menu from the week before and some temp logs and visitor logs." The investigator advised LALD-C no one from this office had reached out requesting information so it could have been an infectious disease related department. LALD-C stated they looked at the facility menu and saw it did have pork but "that all comes to us pre cooked." LALD-C stated they would typically talk to the leadership team if issues came up but also wouldn't share certain things due to "patient confidentiality." LALD-C stated, "I think the difference is we didn't see it as a foodborne illness because we didn't hear from the hospital right away." LALD-C stated the issue would have been considered a reportable event as staff had been made aware of the diagnosis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		