STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS AT AMELIA	8830 VIRGINIA STREET AMELIA, VA 23002

(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 An unannounced Medicare/Medicaid revisit survey to the standard survey conducted on 4/2/19 through 4/5/19 was conducted 5/14/19 through 5/15/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 100 certified bed facility was 92 at the time of the survey. The survey sample consisted of 12 current resident reviews, Residents #101 through #112.	{F 000}	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 2567. The facility is completing the allegation of compliance because it is required by State and Federal law. The facility disagrees with the alleged deficiencies as stated and the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the alleged deficiencies. This includes, but is not limited to, the alleged content / summary of interviews, the timing / chronological sequence of events and contact with health care professionals, and the description of the care provided to the residents. The facility reserves its right to continue disputing, appealing and contesting these alleged deficiencies and taking any action related to or arising therefrom in any other forum as needed.	
{F 695}	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to store respiratory equipment in a sanitary manner for two of 12 residents in the survey sample, Residents # 106 and # 107. 1. For Resident # 106, facility staff failed to store the mouth piece for a nebulizer in a sanitary	{F 695}	**F 695** It is the practice of this facility to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan. I On 5/14/19 the oxygen tubing and nebulizer with nebulizer tubing was placed in plastic bags per facility guideline.	6-3-19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ryan Finch, LNHA | TITLE: Administrator | (X5) DATE: May 30, 2019

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 695}	Continued From page 1 manner. 2. For Resident # 107, facility staff failed to store a nasal cannula in a sanitary manner. The findings include: 1. For Resident # 106, facility staff failed to store the mouth piece for a nebulizer in a sanitary manner. Resident # 106 was admitted to the facility on 10/05/2018 with diagnoses that included but were not limited to shortness of breath, hypertension (1) and atrial fibrillation (2). Resident # 106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/11/19, coded Resident # 106 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 106 was coded as requiring extensive assistance of one staff member for activities of daily living. On 05/14/19 at 12:35 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the nebulizer tubing and hanging from the side of the bed uncovered. On 05/14/19 at 2:50 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the	{F 695}	**II** Facility nursing staff will maintain respiratory equipment per standards of practice and care plan and by following infection control practices. **III** On or before, June 3, 2019, the DON, Unit Managers or designee will complete an educational review for licensed nurses and nursing aides, either in person or by phone, regarding oxygen and nebulizers including: • Store O2 set up in plastic bag when not in use. • Check O2 tubing when they enter a room to ensure infection control is maintained. Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift	

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{F 695}	Continued From page 2 nebulizer tubing and hanging from the side of the bed uncovered. On 05/14/19 at 3:55 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the nebulizer tubing and hanging from the side of the bed uncovered. The POS (physician's order sheet) for Resident # 106 dated 05/2019 documented, "Albuterol sulfate (3) solution for nebulization. 3ML (three milliliter) via (by) Nebulizer; Inhalation. Start Date: 04/11/2019." The comprehensive care plan with dated of 04/11/19 for Resident # 106 documented, "Problem: Cardiac." Under "Approach" it documented, "Administer medications: AS ORDERED. Start Date: 04/11/2019." On 05/14/19 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how the mouth piece for a nebulizer should be store when not in use LPN # 1 stated, "It should be placed in a plastic bag." When asked why the mouth piece should be stored in a plastic bag LPN # 1 stated, "To prevent contamination." After observing the mouth piece for the nebulizer hanging off the side of Resident # 106's bed with this surveyor LPN # 1 stated, "It should be placed in a bag." The facility's policy "Oxygen Therapy - Aerosol Treatment" documented, "Store O2 set in a plastic bag." On 05/15/19 at 9:05 a.m., ASM (administrative	{F 695}	**IV** Beginning May 15, 2019, the DON, Unit Managers or designee will conduct audits of residents on oxygen and respiratory treatments to validate that the oxygen is being delivered per MD orders, that oxygen/ nebulizer tubing is bagged and stored under infection control procedures. This audit will take place on 20% of the residents with oxygen, 5 days per week for 1 week, then 2 times per week for 1 week then weekly for 8 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the DON, monthly, to the QAPI (Quality Assessment Performance Improvement) committee for its review and recommendations. The QAPI committee consists of the facility Administrator, Director of Nursing, Unit Managers, Infection control preventionist, Business office manager, maintenance director and facility medical director, who attends at least quarterly.	

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{F 695}	Continued From page 3 staff member) # 3, vice president of clinical services was made aware of the above findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (3) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html 2. For Resident # 107, facility staff failed to store a nasal cannula in a sanitary manner.	{F 695}		

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{F 695}	Continued From page 4 Resident # 107 was admitted to the facility on 09/25/2017 with diagnoses that included but were not limited to heart failure (1), peripheral vascular disease (2) and chronic kidney disease (3). Resident # 107s most recent MDS (minimum data set), a 14-Day assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 107 as scoring a 5 (five) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 5 (five) - being XX impaired of cognition for making daily decisions. Resident # 107 was coded as being independent and requiring set-up only for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 107 as receiving "Oxygen therapy." On 05/14/19 at 12:35 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was uncovered and lying in the seat of the wheelchair. On 05/14/19 at 2:50 p.m., an observation of Resident # 107's room was conducted Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute95. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was uncovered and lying in	{F 695}		

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{F 695}	Continued From page 5 the seat of the wheelchair. On 05/14/19 at 3:55 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was placed in a plastic bag and lying in the seat of the wheelchair. The POS (physician's order sheet) for Resident # 107 dated 05/2019 documented, "O2 (oxygen) @ 2L/min (two liters per minute) via (by) NC (nasal cannula) s needed. Start Date: 04/26/2019." The comprehensive care plan with a target date of 7/15/19 for Resident # 107 documented, "Problem: Cardiac." Under "Approach" it documented, "Administer oxygen per orders. Observe oxygen precautions. BE SURE THERE IS O2 IN THE TANK EACH SHIFT." On 05/14/19 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how a nasal cannula should be store when not in use LPN # 1 stated, "It should be placed in a plastic bag." When asked why the nasal cannula should be stored in a plastic bag LPN # 1 stated, "To prevent contamination." When informed of the observations of Resident # 107's nasal cannula uncovered sitting on the seat of the resident's wheelchair LPN # 1 stated, "It should have been put in a bag." When asked if he had placed the nasal cannula in the bag LPN # 1 stated. "No. I don't know who did."	{F 695}		

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{F 695}	Continued From page 6 The facility's policy "Oxygen Therapy - Mask and Nasal Cannula" documented, "When masks and cannulas are not in use, store in plastic bag, do not let tubing drag on the floor." On 05/15/19 at 9:05 a.m., ASM (administrative staff member) # 3, vice president of clinical services was made aware of the above findings. No further information was provided prior to exit. References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (2) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	{F 695}		
{F 880}	Infection Prevention & Control	{F 880}		

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{F 880} SS=D	Continued From page 7 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, 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	{F 880}	**F 880** It is the practice of this facility to 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. **I** On 5/14/19 the oxygen tubing and nebulizer with nebulizer tubing was placed in plastic bags per facility guideline. **II** Facility nursing staff will maintain respiratory equipment per standards of practice and care plan and by following infection control practices. **III** On or before, June 3, 2019 the DON, Unit Managers or designee will complete an educational review for licensed nurses and nursing aides, either in person or by phone, regarding oxygen and nebulizers including: • Store O2 set up in plastic bag when not in use. • Check O2 tubing when they enter a room to ensure infection control is maintained.	6-3-19

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{F 880}	Continued From page 8 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. §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: Based on observation, staff interview, clinical record review and facility document review, it was determined that facility staff failed to implement infection control practices for two of 12 residents in the survey sample, Residents # 106 and # 107. 1. The facility staff failed to implement infection control practices for the storage of Resident # 106's mouth piece for a nebulizer.	{F 880}	Newly hired nursing staff and agency staff will receive this education during orientation. Any PRN staff or those currently on FMLA, LOA or vacation will receive this education prior to beginning their next scheduled shift **IV** Beginning May 15, 2019, the DON, Unit Managers or designee will conduct audits of residents on oxygen and respiratory treatments to validate that the oxygen is being delivered per MD orders, that oxygen/ nebulizer tubing is bagged and stored under infection control procedures. This audit will take place on 20% of the residents with oxygen, 5 days per week for 1 week, then 2 times per week for 1 week then weekly for 8 weeks. Any discrepancy noted during the audit will be addressed at that time. Results of the audit will be submitted, by the DON, monthly, to the QAPI (Quality Assessment Performance Improvement) committee for its review and recommendations.	

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{F 880}	Continued From page 9 2. The facility staff failed to implement infection control practices for the storage of Resident # 107's nasal cannula. The findings include: 1. The facility staff failed to implement infection control practices for the storage of Resident # 106's mouth piece for a nebulizer. Resident # 106 was admitted to the facility on 10/05/2018 with diagnoses that included but were not limited to shortness of breath, hypertension (1) and atrial fibrillation (2). Resident # 106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/11/19, coded Resident # 106 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 106 was coded as requiring extensive assistance of one staff member for activities of daily living. On 05/14/19 at 12:35 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the nebulizer tubing and hanging from the side of the bed uncovered. On 05/14/19 at 2:50 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the nebulizer tubing and hanging from the side of the	{F 880}		

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{F 880}	Continued From page 10 bed uncovered. On 05/14/19 at 3:55 p.m., an observation of Resident # 106's room was conducted. Resident # 106 was observed lying in his bed watching television. Further observation revealed the mouth piece for the nebulizer was attached to the nebulizer tubing and hanging from the side of the bed uncovered. The POS (physician's order sheet) for Resident # 106 dated 05/2019 documented, "Albuterol sulfate (3) solution for nebulization. 3ML (three milliliter) via (by) Nebulizer; Inhalation. Start Date: 04/11/2019." The comprehensive care plan with dated of 04/11/19 for Resident # 106 documented, "Problem: Cardiac." Under "Approach" it documented, "Administer medications: AS ORDERED. Start Date: 04/11/2019." On 05/14/19 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how the mouth piece for a nebulizer should be store when not in use LPN # 1 stated, "It should be placed in a plastic bag." When asked why the mouth piece should be stored in a plastic bag LPN # 1 stated, "To prevent contamination." After observing the mouth piece for the nebulizer hanging off the side of Resident # 106's bed with this surveyor LPN # 1 stated, "It should be placed in a bag." The facility's policy "Oxygen Therapy - Aerosol Treatment" documented, "Store O2 set in a plastic bag " On 05/15/19 at 9:05 a.m., ASM (administrative staff member) # 3, vice president of clinical	{F 880}		

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{F 880}	Continued From page 11 services was made aware of the above findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (3) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html. 2. The facility staff failed to implement infection control practices for the storage of Resident # 107's nasal cannula.	{F 880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 880}	Continued From page 12 Resident # 107 was admitted to the facility on 09/25/2017 with diagnoses that included but were not limited to heart failure (1), peripheral vascular disease (2) and chronic kidney disease (3). Resident # 107s most recent MDS (minimum data set), a 14-Day assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 107 as scoring a 5 (five) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 5 (five) - being XX impaired of cognition for making daily decisions. Resident # 107 was coded as being independent and requiring set-up only for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 107 as receiving "Oxygen therapy." On 05/14/19 at 12:35 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was uncovered and lying in the seat of the wheelchair. On 05/14/19 at 2:50 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute95. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was uncovered and lying in	{F 880}		

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{F 880}	Continued From page 13 the seat of the wheelchair. On 05/14/19 at 3:55 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was placed in a plastic bag and lying in the seat of the wheelchair. The POS (physician's order sheet) for Resident # 107 dated 05/2019 documented, "O2 (oxygen) @ 2L/min (two liters per minute) via (by) NC (nasal cannula) s needed. Start Date: 04/26/2019." The comprehensive care plan with a target date of 7/15/19 for Resident # 107 documented, "Problem: Cardiac." Under "Approach" it documented, "Administer oxygen per orders. Observe oxygen precautions. BE SURE THERE IS O2 IN THE TANK EACH SHIFT." On 05/14/19 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how a nasal cannula should be store when not in use LPN # 1 stated, "It should be placed in a plastic bag." When asked why the nasal cannula should be stored in a plastic bag LPN # 1 stated, "To prevent contamination." When informed of the observations of Resident # 107's nasal cannula uncovered sitting on the seat of the resident's wheelchair LPN # 1 stated, "It should have been put in a bag." When asked if he had placed the nasal cannula in the bag LPN # 1 stated, "No, I don't know who did."	{F 880}		

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{F 880}	Continued From page 14 The facility's policy "Oxygen Therapy - Mask and Nasal Cannula" documented, "When masks and cannulas are not in use, store in plastic bag, do not let tubing drag on the floor." On 05/15/19 at 9:05 a.m., ASM (administrative staff member) # 3, vice president of clinical services was made aware of the above findings. No further information was provided prior to exit. References: (1) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (2) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	{F 880}		