STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G643	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	1006 W 11TH ST BLOOMINGTON, IN 47404

(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
W000000	This visit was for the post certification revisit to the fundamental recertification and state licensure survey completed on 11/15/13. Survey Dates: March 13 and 14, 2014 Facility Number: 001221 Provider Number: 15G643 AIM Number: 100240220 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/27/14 by Ruth Shackelford, QIDP.	W000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 6 of 40 incident/investigative reports reviewed affecting clients #5 and #6, the facility failed to implement its policies and procedures for preventing abuse of the clients, reporting an incident to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner, completing an investigation of client to client abuse within 5 working days and conducting an investigation into client to client abuse. Findings include: A review of the facility's incident/investigative reports was conducted on 3/13/14 at 11:08 AM and indicated the following: 1. On 11/29/13 the Director of Supported Living Program requested an investigation into the alleged abuse of client #5 by former staff #8. Staff #8 was alleged to have punched client #5 on the back of the head. The investigation, dated 12/4/13, indicated in the Findings section "Substantiated, the findings support the event as described/allegation." The investigation	W000149	W149 Plan of correction: Facility staff received retraining on prevention of abuse, neglect and exploitation on 1/3/14. Facility operated day program staff received retraining on prevention of abuse, neglect and exploitation on 3/3/14. Since the trainings, there has only been incident involving client to client aggression. Facility staff will receive retraining on Client #5's BSP, focusing on proactive strategies to prevent peer to peer aggression. The trainings on prevention of abuse, neglect and exploitation also included details on incident reporting, including when, how and who to report incidents of client to client aggression. Please see attachment W149. Plan of prevention: The agency has improved a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The process includes the following steps: The written incident report is submitted within 24 hours (or immediately if it contains an allegation A/N/E) to a designated administrative staff. The staff enters the incident into the electronic	04/13/2014

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	indicated, "Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual... The reports of the perpetrator and the witnesses are consistent with the exception of how many times that [staff #8] hit [client #5]. [Staff #8] reported hitting [client #5] once and [staff #4] reports [staff #8] hit [client #5] twice. [Staff #8] does not appear to be is (sic) trying to minimize what happened. He was clearly remorseful and acknowledged what he had done. He did this openly and without hesitation. He did not try to justify his actions, and acknowledged what he did was wrong... Agency policy was not followed in that an unauthorized transport procedure was utilized to transport [client #5] to his room, although this violation did not cause any risk of injury to [client #5]. It is recommended that staff be trained on appropriate transports and physical holds." Staff #8 was terminated on 12/10/13. 2. On 1/31/14 at 10:10 AM at the facility-operated day program, client #6 became frightened when another client tripped and fell over client #6's chair. Client #6 grabbed a peer's hair tightly for 10-20 seconds.		system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if indicated and sends an electronic copy of the report to the facility support team. Each member of the support team reads, reviews, documents actions taken and signs the report. The agency's electronic incident reporting system now includes review by coordinators and directors across program areas serving each client. Quality Assurance Monitoring: The QA team process has been revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA team will recommend and monitor corrective actions. Program and IT Directors continue to monitor the agency's new electronic reporting/reviewing system for systemic issues or concerns to be addressed, as its implementation is still new. Facility coordinator will complete Quality Assurance Monitoring Checklist monthly for the next quarter. The checklist includes monitoring of the implementation of policies and procedures that prohibit mistreatment, neglect, or abuse of clients.	

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	3. On 1/21/14 at 7:40 AM, client #5 lunged toward client #6 and grabbed his arm. Client #6 had a red mark on his right wrist/arm where client #5 grabbed him. 4. On 1/13/14 at 2:50 PM at the facility operated day program, client #6 was hugging staff and grabbed the staff's hair. When client #6 released the staff's hair he grabbed a female peer's handkerchief that was around her neck. Client #6 scratched the peer's neck leaving four scratch marks. There was no documentation the incident was investigated. 5. On 12/23/13 at 11:45 AM at the facility operated day program, client #6 grabbed a female peer's collar of her shirt. Client #6 left five scratches on the back of the peer's neck and redness on the front of her neck from pulling on her shirt collar. The investigation, dated 12/27/13, was reviewed by the administrator on 1/9/14. 6. On 11/28/13 at 3:18 PM (reported to BDDS on 12/4/13) client #5 "attacked staff" and was escorted to his room. Client #5 came back into the hallway and "attacked" staff again and was escorted to his room. While in his room, client #5 engaged in "severe" SIB (self injurious			

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	behavior) and once he calmed down he came out and the bridge of his nose had a cut that was bleeding. The BDDS report indicated, "Staff failed to turn in this incident report in a timelty (sic) fashion." On 3/13/14 at 12:21 PM, the Director of the group homes indicated BDDS reports were to submitted within 24 hours. The Director indicated the facility had a policy/procedure prohibiting abuse. The Director indicated the facility should prevent abuse of the clients. On 3/14/14 at 1:09 PM the Director indicated the facility should investigate all incidents of abuse. The Director indicated investigations should be completed within 5 working days of the incident. On 3/14/14 at 12:09 PM, a review of the facility's policies and procedures was conducted. The Behavioral Intervention Policy, dated 9/2013, indicated, in part, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the			

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	responsible party which results in risk of physical harm and/or emotional trauma. Emotional/Verbal abuse: Consists of the intentional use of actions, words, or activities where an individual suffers emotional/psychological harm or trauma. This includes, but is not limited to the following: 9. Intimidation/Coercion: To dominate, force or bring about by force, fear or threat behavior or compliance." The Incident Reporting Procedure, dated 9/2010, indicated, in part, "...are to be reported to the State following state guidelines and timeframes. The Investigation Protocols, dated 8/2010, indicated, in part, "Investigations involving consumers in group homes must meet the ICF/MR (Intermediate Care Facility/Mental Retardation) regulations including completion of all investigations within 5 working days." This deficiency was cited on 11/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 40 incident/investigative reports reviewed affecting client #5, the facility failed to report an incident to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 3/13/14 at 11:08 AM and indicated the following: On 11/28/13 at 3:18 PM (reported to BDDS on 12/4/13) client #5 "attacked staff" and was escorted to his room. Client #5 came back into the hallway and "attacked" staff again and was escorted to his room. While in his room, client #5 engaged in "severe" SIB (self injurious behavior) and once he calmed down he came out and the bridge of his nose had a cut that was bleeding. The BDDS report indicated, "Staff failed to turn in this incident report in a timelty (sic) fashion."	W000153	W153 Plan of correction: Facility staff received retraining on incident reporting, including reporting to BDDS within 24 hours, in accordance with state law on 1/3/14. Please see attachment W153. This training also included details on incident reporting, including when, how and who to report incidents of client to client aggression. Plan of prevention: The agency's incident reports are available electronically and can be submitted to the administrator or other officials immediately. The agency provides on call staff during overnight and weekend hours to submit reports to BDDS and other officials within 24 hours in accordance with state law. On call staff will receive retraining on reporting incidents to BDDS and other officials within 24 hours of the incident by 4/11/14. Quality assurance monitoring: The	04/13/2014

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	On 3/13/14 at 12:21 PM, the Director of the group homes indicated BDDS reports were to submitted within 24 hours. This deficiency was cited on 11/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		agency's QA process has been revised to include a review and report of all ISDH surveys by a third party QA member including failure to comply with state law regarding A/N/E reports and the QA team will recommend and monitor corrective actions. Program and IT Directors continue to monitor the agency's new electronic reporting/reviewing system for systemic issues or concerns to be addressed, as its implementation is still new.	

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 40 incident/investigative reports reviewed affecting client #6, the facility failed to conduct an investigation of client to client abuse. Findings include: A review of the facility's incident/investigative reports was conducted on 3/13/14 at 11:08 AM and indicated the following: On 1/13/14 at 2:50 PM at the facility operated day program, client #6 was hugging staff and grabbed the staff's hair. When client #6 released the staff's hair he grabbed a female peer's handkerchief that was around her neck. Client #6 scratched the peer's neck leaving four scratch marks. There was no documentation the incident was investigated. On 3/13/14 at 12:21 PM, the Director of the group homes indicated the facility should investigate all incidents of abuse. This deficiency was cited on 11/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence.	W000154	W154 Plan of correction: Facility operated day program staff received retraining on prevention of abuse, neglect and exploitation which includes incident reporting regulations on 3/3/14. Facility operated day program coordinators received training on conducting thorough investigations by 4/13/14. This training also included details on incident reporting, including when, how and who to report incidents of client to client aggression. Plan of prevention: The agency's electronic incident reporting system has been reviewed by program directors and IT director. Appropriate adjustments have been made to ensure incident reports are entered and sent to support teams and across program areas to be reviewed. Client to client aggression inquiries are attached and sent to coordinators for completion. Quality assurance monitoring: The agency's QA process has been revised to include a review and	04/13/2014

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	9-3-2(a)		report of all ISDH surveys by a third party QA member including failure to do follow up investigations on allegations A/N/E, injuries of unknown source, and client elopement and the QA team will recommend and monitor corrective action. Program and IT Directors continue to monitor the agency's new electronic reporting/reviewing system for systemic issues or concerns to be addressed, as its implementation is still new.	

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W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 40 incident/investigative reports reviewed affecting client #6, the facility failed to report the results of an investigation to the administrator within five working days of the incident. Findings include: A review of the facility's incident/investigative reports was conducted on 3/13/14 at 11:08 AM and indicated the following: On 12/23/13 at 11:45 AM at the facility operated day program, client #6 grabbed a female peer's collar of her shirt. Client #6 left five scratches on the back of the peer's neck and redness on the front of her neck from pulling on her shirt collar. The investigation, dated 12/27/13, was reviewed by the administrator on 1/9/14. On 3/13/14 at 1:09 PM, the Director indicated investigations should be completed within 5 working days of the incident. 9-3-2(a)	W000156	W156 Plan of correction: Facility operated day program staff received retraining on prevention of abuse, neglect and exploitation which includes incident reporting regulations on 3/3/14. Facility operated day program coordinators received training on conducting thorough investigations by 4/13/14. Plan of prevention: An electronic alert system has been implemented to alert program directors on the fifth day following incidents of client to client aggression that results of the investigation are due. Quality assurance monitoring: Director of SGL has created changes to the inquiry reporting form to identify a designated administrator when the director is not immediately available to review client to client inquiry reports.	04/13/2014

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W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 5 of 5 clients living at the group home (#1, #3, #4, #5 and #6), the facility failed to ensure there was sufficient staff to manage and supervise the clients during the overnight shift (10:00 PM to 6:00 AM). Findings include: A review of the facility's evacuation drills was conducted on 3/13/14 at 3:59 PM. On 12/4/13 at 10:30 PM an overnight shift fire drill was conducted with three staff (the Qualified Intellectual Disabilities Professional, Home Manager and one direct care staff). The drill took 23 minutes to complete. The drill indicated, in part, "All clients asleep. [Client #4] and [client #6] couldn't hear the alarm, were confused and combative while trying to convince them what we were doing. [Client #5] went into a tantrum, with SIBs (self injurious behavior); very groggy due to his high HS	W000186	W186 Plan of correction: A facility specific evacuation plan has been implemented. Facility clients and staff have engaged in intensive teaching and training around overnight fire drills. The facility has been successfully evacuated with current overnight staffing patterns. Plan of prevention: The facility will conduct overnight fire drills once a month for the next quarter, fading to two overnight drills per quarter for one quarter, fading to one overnight fire drill per quarter. Quality assurance monitoring: Facility Coordinator will complete Quality Assurance Monitoring Checklist monthly for the next quarter which includes monitoring of sufficient/appropriate staff to implement objectives and the	04/13/2014

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	(hour of sleep) dose of Seroquel. [Client #1] refused to get out of bed and was yelling at staff, took the longest to engage in the drill. [Clients #1 and #6] both required multiple prompts." The plan of correction for the drill indicated, "The team will discuss. A plan will be put in place to ensure efficient evacuation of all clients. The team will execute more drills to address the time issue." The facility did not conduct additional overnight shift drills. On 3/14/14 at 10:25 AM, the Director indicated she thought additional overnight shift (10:00 PM to 6:00 AM) drills were conducted. The Director indicated 23 minutes to complete a drill was a long time. The Director indicated the targeted time for completing drills was 90 seconds. The Director indicated a plan was developed by the Coordinator after the last survey. The Director stated the Coordinator seemed "very confident" the plan he developed would be successful. The Director indicated the facility needed to conduct additional drills during the overnight shift to verify the plan would address the issues noted during the 12/4/13 drill. The Director indicated the facility had no documentation the plan the Coordinator developed was implemented. The Director indicated the facility should have		completion of evacuation drills.	

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	conducted more drills. The Director indicated there was one staff assigned at the home from 10:00 PM to 6:00 AM. This deficiency was cited on 11/15/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 non-sampled clients (#4), the facility's nursing services failed to ensure staff documented the implementation of client #4's risk plan for diabetes. Findings include: A review of client #4's record was conducted on 3/14/14 at 10:44 AM. Client #4's Medication Information Sheet (MIS), dated 2/24/14, indicated he had a risk plan for High Blood Sugar Readings. The plan indicated when his blood sugar was between 150 to 250, the staff were to push water, encourage cardiovascular activity and recheck his blood sugar at the next scheduled time. When client #4's blood sugar was 251 to 400, the staff were to hold snacks (not meals), push water, encourage activity (walking), and recheck his blood sugar in 2 hours. When client #4's blood sugar was greater than 400, the staff were to recheck his blood sugar, if still greater than 400, call the pager. If there was no response from the pager within 15 minutes, call 911. The MIS indicated, in bold, "For all blood sugar readings: Record on Med Administration Record (MAR) any actions and the response." Client #4's	W000331	W331 Plan of correction: Facility staff have received training on documenting implementation of Client #4's risk plan on 4/4/14. Please see attachment W331. Review of medication logs indicates this deficiency did not effect other facility clients. Plan of prevention: All incoming facility staff will be trained on properly documenting implementation of clients' risk plans. Quality assurance monitoring: To ensure proper documentation of implementation of risk plans, facility nurse will review documentation weekly for the next quarter, fading to twice monthly for one quarter, and fading to monthly documentation review.	04/04/2014

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 W 11TH ST BLOOMINGTON, IN 47404	

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	MARs for August, September, October, November and December 2013 as well as January and March 2014 (the facility was unable to provide the February 2014 documentation) indicated the staff did not record their actions and responses on client #4's MAR. There was no documentation in the client #4's record indicating the staff implemented client #4's risk plan for diabetes. In March 2014, there were 25 times client #4's blood sugar was greater than 150. In January 2014, there were 44 times clients #4's blood sugar was greater than 150. In December 2013, there were 59 times clients #4's blood sugar was greater than 150. In November 2013, there were 45 times clients #4's blood sugar was greater than 150. In October 2013, there were 36 times clients #4's blood sugar was greater than 150. In September 2013, there were 38 times clients #4's blood sugar was greater than 150.			

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	In August 2013, there were 42 times clients #4's blood sugar was greater than 150. On 3/14/14 at 10:35 AM, the Director indicated the staff should implement client #4's plan as written. The Director indicated the staff needed to document their actions taken. On 3/14/14 at 12:25 PM, the nurse indicated the staff needed to initial the MAR and chart on the back of the MAR the actions taken to address his high blood sugar. The nurse indicated the staff needed to implement the plan as written. 9-3-6(a)			

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W000449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview for 5 of 5 clients living at the group home (#1, #3, #4, #5 and #6), the facility failed to implement the corrective action recommended to address issues noted during an overnight evacuation drill. Findings include: A review of the facility's evacuation drills was conducted on 3/13/14 at 3:59 PM. On 12/4/13 at 10:30 PM an overnight shift (10:00 PM to 6:00 AM) fire drill was conducted with three staff (the Qualified Intellectual Disabilities Professional, Home Manager and one direct care staff). The drill took 23 minutes to complete. The drill indicated, in part, "All clients asleep. [Client #4] and [client #6] couldn't hear the alarm, were confused and combative while trying to convince them what we were doing. [Client #5] went into a tantrum, with SIBs (self injurious behavior); very groggy due to his high HS (hour of sleep) dose of Seroquel. [Client #1] refused to get out of bed and was yelling at staff, took the longest to engage in the drill. [Clients #1 and #6] both required multiple prompts." The plan of	W000449	W449 Plan of correction: Facility staff have received training on conducting evacuation drills according to state regulations on 3/21/14. A facility specific evacuation plan has been implemented. The facility clients and staff have engaged in intensive teaching and training around overnight fire drills. The facility has been successfully evacuated during overnight four shifts since 3/18/14. Please see attachment W449. Plan of prevention: Facility coordinator will assign dates for evacuation drills to occur and keep posted in the facility office. Quality assurance monitoring: The facility will conduct overnight evacuation drills once a month for the next quarter, fading to two overnight evacuation drills per quarter, fading to one overnight evacuation drill per quarter, in addition to the required morning and afternoon evacuation drills.	04/13/2014

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	correction for the drill indicated, "The team will discuss. A plan will be put in place to ensure efficient evacuation of all clients. The team will execute more drills to address the time issue." The facility did not conduct additional overnight shift drills to evaluate the effectiveness of the newly developed plan. A review of the facility's Emergency Fire Drill Evacuation Plan, not dated, was conducted on 3/14/14 at 1:26 PM. The plan indicated, "In the event of an emergency, especially one that occurs during the hours of 10P and 6A, when one staff is present, staff should do the following: 1) Alert all clients by knocking on their doors. 2) Awake [client #5] and take him out to his [name] van and ensure that he is safe. 3) Ensure that [client #3] is awake and have him exit the house, if he has done so independently. 4) Ensure that [client #6] is awake and assist him in preparing to leave the house. 5) Ensure that [client #1] is awake and assist him in preparing to leave the house. 6) If [client #4] is not already up, prompt him with physical and verbal cues to get him moving. 7) Assist [client #2] with getting out of the house into the van." On 3/14/14 at 10:25 AM, the Director			

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	indicated she thought additional overnight shift (10:00 PM to 6:00 AM) drills were conducted after the drill on 12/4/13. The Director indicated 23 minutes to complete a drill was a long time. The Director indicated the targeted time for completing drills was 90 seconds. The Director indicated a plan was developed by the Coordinator after the last survey. The Director stated the Coordinator seemed "very confident" the plan he developed would be successful. The Director indicated the facility needed to conduct additional drills during the overnight shift to verify the plan would address the issues noted during the 12/4/13 drill. The Director indicated the facility had no documentation the plan the Coordinator developed was implemented. The Director indicated the facility should have conducted more drills. 9-3-7(a)			