

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2014
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NAME OF PROVIDER OR SUPPLIER  HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN 46792
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F000000	<p>This visit was for the Investigation of Complaint IN00155848.</p> <p>Complaint IN00155848 - Substantiated. Federal/State deficiencies related to the allegations are cited at F203, F309 and F323.</p> <p>Survey dates: September 17 and 18, 2014</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF: 10 SNF/NF: 130 Residential: 177 Total: 317</p> <p>Census payor type: Medicare: 10 Medicaid: 70 Other: 237 Total: 317</p> <p>Sample: 3</p>	F000000	<p>Heritage Pointe is submitting our facility's plan of correction to the deficiencies of the Complaint Survey conducted by your department on September 17th and 18th 2014 Submission of this plan of correction shall not constitute or be construed as an admission by Heritage Pointe that the allegations in the survey report are accurate or reflect accurately the provision of nursing care and service to the residents at Heritage pointe. This Plan of correction serves as our allegation of compliance that by October 2, 2014, Heritage Pointe will have corrected the cited deficiencies and have all systemic changes implemented to comply with State and Federal regulations. In view of the fact that the noted deficiencies cited fall at a level D with no quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidenced of correction to confirm our substantial compliance in lieu of an on-site visit. Please note the facility is requesting an IDR paper review</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F000203 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this</p>			

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	<p>section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on interview and record review, the facility failed to provide the Power of Attorney (POA) with the written appeal right of an intra-facility transfer for 1 of 1 residents reviewed. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident (B) was reviewed on 9/17/14 at 8:50 a.m. Diagnoses for the resident included, but were not limited to, dementia, joint hip replacement, chronic kidney disease,</p>	F000203	<p><b>Plan of correction: F 203</b></p> <p><b>Please note the facility reviewed the notice of intra-facility transfer notice with the POA of resident B and the POA signed the consent prior the transfer without any questions. Please note the facility is requesting an IDR (paper review) Please see attachment for IDR rationale How other residents were identified for the potential to be affected by the same deficient practice? Reviewed all transfers occurring within last</b></p>	10/02/2014

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	<p>hypertension, macular degeneration and hearing loss.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/14, indicated Resident (B) was severely cognitively impaired.</p> <p>During an interview on 9/17/14 at 1:20 p.m., family members of Resident (B) provided a written follow-up from a meeting with the facility from 9/11/14. The information indicated the family voiced concerns related to moving Resident (B) from her current unit to another unit within the facility. The follow-up letter indicated the facility did fail to provide the family with the information, a statement related to the right to appeal the transfer.</p> <p>During an interview on 9/17/14 at 3:45 p.m., the Administrator indicated the facility failed to provide the family with information related to resident right's and the appeal process of a intra-facility transfer for Resident (B).</p> <p>During an interview on 9/18/14 at 10:00 a.m., Social Worker #3 indicated the family of Resident (B) had made previous concerns related to Resident (B) moving from one unit to another. They did not want the resident moved and felt</p>		<p>month to see what other residents had the potential to be affected by the same practice. <b>What corrective action for residents found to have been affected by the same deficient practice were put into place?</b> Social Service staff in-service regarding intra-facility transfers. (Exhibit A) <b>Measures put into place or changes that will be made to prevent reoccurrence</b> Upon admission to the facility all residents will be given a copy of "resident's rights" per facility policy. Ongoing A care plan with the family/resp party will be requested prior to all intra-facility transfers. If the resp. party/family is unable to attend, the care team within the facility shall hold a care-plan involving no less than a Social Services representative, the discharging nurse and the receiving nurse, and a member of nursing management. (Exhibit B) 9/30/14-ongoing Upon all intra-facility transfers family/resp. party will be provided with a copy of the intra-facility discharge form which will explain the right to dispute a transfer. 9/30/14-ongoing Facility will request Resp. party/family to sign the intra-facility discharge form acknowledging receipt of "resident's rights" and notification of how to dispute an intra-facility transfer. 9/30/14 - ongoing Social Services will complete a follow up interview with family 2</p>				

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F000309 SS=D	<p>she was doing well in her current unit.</p> <p>This Federal tag relates to Complaint IN00155848.</p> <p>3.1-12(a)(9)(D)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to implement a management plan with individualized interventions for maladaptive behaviors for 1 of 3 residents reviewed for behavior management. (Resident C)</p> <p>Findings include:</p>	F000309	<p>weeks after the transfer to ensure compliance and identify any issues related to the transfer.</p> <p>9/30/14- ongoing <b>How corrective action(s) will be monitored to prevent reoccurrence.</b> Administrator will review transfer form and the care plan notes, to ensure compliance prior to any transfer/discharge. 9/30/14- ongoing All transfers/discharge will be reviewed by the Q.A. committee for guidance/recommendations. Ongoing Any non-compliance will be reviewed by the Q.A. committee for appropriate action. Ongoing</p> <p><b>Plan of correction: F 309</b> <b>Please note resident Chad multiple interventions that have been trialed with resident. Resident C has had many medications adjustments through palliative care physician in order to reduce behaviors along with non-pharmacological interventions. In addition resident is on behavior management program with</b></p>	10/02/2014			

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	<p>Resident (C) was observed on 9/17/14 at 11:05 a.m. in the lounge area of the locked unit. Resident (C) got up and went down towards her room to the exit door, attempting to open it. Resident (C) was redirected to sit down, but turned towards another door to a separate unit and attempted to exit. Staff continued to walk with the resident and Resident (C) continued with nonsensical talk. No additional interventions were attempted.</p> <p>On 9/17/14 at 2:00 p.m., Resident (C) walked up to writer and softly poked writer in the left side of the cheek and spoke with nonsensical talk. Resident (C) was redirected to continue to walk with staff member. No additional interventions were attempted.</p> <p>The clinical record for Resident (C) was reviewed on 9/17/14 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, restless leg syndrome, anxiety, depressive disorder and chronic pain.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 7/28/14, indicated Resident (C) was severely cognitively impaired.</p> <p>During review of the Mood and Behavior weekly report, provided by the</p>		<p><b>psychologist consulting on aregular basis. To promote continuity of care the facility has attempted tomanage residents with behaviors within the facility and yet provide a safeenvironment for all residents. Resident C has never exhibited aggressive orthreatening behaviors. Any resident that exhibits threatening or aggressivebehaviors that cannot be treated appropriately within the facility aretransferred for short term in-patient psychiatric treatment. Please note the facility is requesting and IDR (paper review) Please see attachment for IDR rationale How other residentswere identified for the potential to be affected by the same deficientpractice? Care team reviewed all residents currently on Behaviormanagement. 9/30/14 Residents with similar behaviors had care-plans, andinterventions reviewed and revised as appropriate for individualizedapproaches. 9/30/14 What correctiveaction for residents found to have been affected by the same deficient practicewere put into place? Resident C was seen by Nurse Practioner and had theirmedication reviewed and adjusted on 9/2/14 and again on 9/18/14. All identified residents</b></p>				

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	<p>Administrator on 9/18/14 at 8:15 a.m., during the week of 7/11/14, Resident (C) was noted for wandering, pulling on blinds and pulling items off walls. On 7/14/14, Resident (C) broke the screen out of the dining room window. On 7/17/14, Resident (C) was noted to be agitated, wandering in and out of others' rooms, taking others' personal items and resisting care. Current interventions attempted were not effective; one on one, toileting, fluids and snacks.</p> <p>During the week of 7/22/14, Resident (C) was found pulling off wallpaper, removing clothing from her room and hanging the clothing in another resident's room and pouring baby powder in another resident's room. No interventions were noted.</p> <p>During the week of 8/8/14, Resident (C) was observed wandering in and out of other resident's room and stripped the bed. Resident (C) was sometimes easily redirected with the listed interventions; one on one and walking with the resident.</p> <p>During the week of 8/27/14, Resident (C) was observed to have been wandering in and out of others' rooms and taking items. She was found with a full roll of toilet paper and the toilet paper wrapper was found in another resident's bathroom.</p>		<p>identified exhibiting the same type behaviors were referred to on site psychological providers and appointments scheduled. 9/30/14 New behavior protocol implemented for all residents that exhibit behaviors. 9/30/14 – ongoing In-service provided to staff of new behavior protocol. (Exhibit C) 9/30/14 <b>Measures put into place or changes that will be made to prevent reoccurrence</b> Facility implemented additional on-sight psychological providers to assist with behaviors, interventions, and gradual medication dosage reductions of medications in order for all residents to be provided the opportunity to live with the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 9/17/14 Social services will meet with unit staff daily Monday through Friday during morning rounds to determine efficacy of behavior interventions and develop new interventions as needed. 9/30/14- ongoing All department supervisors will be notified of residents on behavior management and current interventions in order to notify assigned staff on the unit of interventions in place and to identify any further behaviors to ensure a unified approach to behaviors. 9/30/14 - ongoing</p>		

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	<p>Resident (C) was redirected several times but continued to be busy. The only intervention noted was: one on one.</p> <p>Progress notes, dated 9/17/14 at 3:19 p.m., indicated Resident (C) was walking with a CNA, when she walked up to another resident in the dining room and poked the resident on the left side of face.</p> <p>The care plan indicated, on 8/15/13, a problem related to wandering, exit seeking, layering clothes, and dressing inappropriately. The goal for Resident (C) was remain safe within bounds of secured unit, will allow assist with appropriate dressing. Approaches included, but were not limited to encourage resident to be busy in a constructive manner during activities, give gentle cues, reorientation when in wrong room, offer to assist her to her room, find a bathroom, help her find her room to reduce risk of wandering into other residents' rooms, may try offering baby doll.</p> <p>The care plan, dated 8/26/13, indicated a problem related to being verbally aggressive towards staff, peers and husband. The goal for Resident (C) was to interact with staff, peers, and husband without being verbally aggressive. Approaches to the problem included, but</p>		<p><b>How corrective action(s) will be monitored to prevent reoccurrence.</b> Families/resp. parties will continue to be given the opportunity to express concerns. Ongoing Any concerns or lack of will be documented and a signature will be requested. Ongoing Any concerns will be reviewed by administrator and corrective action implemented. Ongoing Concerns/corrective actions will be reviewed by the Q.A. committee. Ongoing Social Services will contact family/responsible party after each Behavior Management Meeting with an update and recommendations after each meeting. 9/30/14- Ongoing</p>				

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	<p>were not limited to: "encourage resident to be busy in constructive manner, friendly and pleasant approach with smile, gently redirect resident away from person she is directing her aggression to, walking with resident outside and may try to redirect with conversation about her pet cat."</p> <p>An interview with CNA #2, on 9/17/14 at 11:25 a.m., indicated Resident (C) was currently being supervised one on one. She indicated she was very difficult to keep track of, especially if her husband was not at her side. She indicated she was just recently provided one on one supervision.</p> <p>An interview with LPN #4 on 9/17/14 at 1:10 p.m., indicated the resident now received one on one supervision. She indicated prior to the constant supervision, the interventions included re-directing Resident (C).</p> <p>An interview, on 9/18/14 at 10:00 a.m., with Social Worker #3 indicated Resident (C) had a short attention span and the facility had tried several different activities such as a nursing box, walking with the resident, giving her a baby doll and watching her. She indicated the resident had a motion sensor in her room that alarmed when she came out, but she</p>			

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F000323 SS=D	<p>continued to go into others' rooms.</p> <p>This Federal tag relates to Complaint IN00155848</p> <p>3.1-34(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide a safe environment for 2 of 3 residents reviewed. This failure resulted in a fall, requiring hospitalization and surgery. (Resident B &amp; Resident C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident (B) was reviewed on 9/17/14 at 8:50 a.m. Diagnoses for the resident included, but were not limited to, dementia, joint hip replacement, chronic kidney disease, hypertension, macular degeneration and hearing loss.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/14, indicated Resident (B) was severely cognitively</p>	F000323	<p><b>Plan of correction: F 323</b> <b>Please note any resident that exhibits threatening or aggressive behaviors that cannot be treated appropriately within the facility are transferred for short term in-patient psychiatric treatment. The goal of Heritage Pointe is to provide a safe, comfortable invigorating and loving environment to all residents residing within the facility. Please note the facility is requesting an IDR (paper review) Please see attachments for IDR rationale How other residents were identified for the potential to be affected by the same deficient practice? Other residents within the unit had the potential to be affected however no other residents were identified at this time to have been affected.</b></p>	10/02/2014

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	<p>impaired.</p> <p>On 9/17/14 at 8:40 a.m., Resident (B) was observed seated in her recliner in her room. Several bruises and healing lacerations were noted above the left eye.</p> <p>Progress notes, dated 8/27/14 at 11:30 a.m., indicated CNA #2 called LPN #4 into Resident (B)'s room. Resident (B) was found lying in the doorway between the bedroom and bathroom on her right side. She was complaining of pain in her left hip and pelvic area. Multiple lacerations and hematomas were noted above the left eye, below the left eye on her cheek bone area, and a hematoma behind left ear. The Power of Attorney (POA) was notified and instructed the facility to send the resident to the hospital. The physician was also notified.</p> <p>Resident (B) was transported on 8/27/14 at 12:15 p.m. Resident (B) returned to the facility with an admitting diagnosis of a left femoral neck fracture.</p> <p>Review of the Incident Detail report, dated 8/27/14 and completed on 9/3/14, indicated the following injuries;</p> <ol style="list-style-type: none"> <li>1. Left cheek skin tear</li> <li>2. Left forehead laceration</li> <li>3. Left eyebrow laceration</li> </ol>		<p>9/26/14 <b>What correctiveaction for residents found to have been affected by the same deficient practicewere put into pace?</b> No other residents were found to be affected however, newbehavior protocol implemented to prevent further incidents. (Exhibit B)</p> <p>9/30/14 <b>Measures put into placeor changes that will be made to prevent reoccurrence</b> A chart review will be completed on any resident causing anyincident of injury, attempted injury, or unintentional injury and placed on thebehavior management program. 9/30/14 - Ongoing The care-plan of any resident causing an incident of injury,attempted injury, or unintentional injury will be reviewed by social servicesand revised as appropriate. 9/30/14 - Ongoing <b>How corrective action(s) will be monitored to prevent reoccurrence.</b> All incidents will continue to be reviewed by the Directorof Nursing and the Administrator. Ongoing Any non-compliance to the proposed plan will be reported tothe Q.A. committee for appropriate action/recommendations. Ongoing Behaviors will be monitored weekly by Social Services andall behaviors will be reported to DON and Administrator in writing.</p>				

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	<p>4. Left back of head/ hematoma 5. Left back of hand/bruise</p> <p>An interview with CNA #2 on 9/17/14 at 11:25 a.m., indicated Resident (C) was walking towards the nurses' station with a full roll of toilet paper in her hand. The CNA removed the toilet paper and was walking with Resident (C) back to her room and saw Resident (B) on the floor. She indicated she went and got LPN #4 to help Resident (B). She indicated she later checked and found blood on the bottom of Resident (C)'s shoes and found an empty toilet paper wrapper on the bathroom floor in Resident (B)'s room.</p> <p>An interview with LPN #4, on 9/17/14 at 1:10 p.m., indicated the family had expressed previous concerns related to Resident (C) entering Resident (B)'s room. The family was concerned with Resident (B) getting up, Resident (C) taking items or Resident (B) getting hurt. The LPN indicated when Resident (B) was found, a large pool of blood was noted in the bathroom with footprints through the blood and out of the room. She indicated an empty wrapper of toilet paper was found on the bathroom floor and Resident (C) was walking with a new roll of toilet paper and was found to have had blood on her shoes. She indicated Resident (C) would have had to walk</p>						

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	<p>over and step around Resident (B) since the bloody footprints were noted in the room.</p> <p>During an interview, on 9/17/14 at 1:20 p.m., family members of Resident (B) provided a written follow-up from a meeting with the facility from 9/11/14. The information indicated the family voiced concerns about another resident on the same unit, wandering into Resident (B)'s room. The facility offered a magnetic stop banner to be placed on her door and the family declined.</p> <p>During an interview, on 9/18/14 at 10:00 a.m., Social Worker #3 indicated the family of Resident (B) had made previous concerns related to Resident (C) wandering into her room. They voiced concerns at a care plan meeting and again at another time. Those concerns were emailed to the Administrator. The family was unhappy Resident (B) was transferred from one locked unit to another.</p> <p>A health care plan problem, dated 9/8/14, indicated Resident (B) had impaired visual function related to macular degeneration. One of the approaches to this problem included, but was not limited to; "tell the resident where you are placing their items." Resident (B)</p>			

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	<p>also had a health care problem related to impaired cognitive function/dementia or impaired thought process related to dementia; at risk for increased confusion and altered mental status. One of the approaches to this problem included, but was not limited to, identify yourself at each interaction, face the resident when speaking and keep resident's routine consistent as possible.</p> <p>2. The clinical record for Resident (C) was reviewed on 9/17/14 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, restless leg syndrome, anxiety, depressive disorder and chronic pain.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 7/28/14, indicated Resident (C) was severely cognitively impaired.</p> <p>The care plan indicated an 8/26/13 problem related to being verbally aggressive towards staff, peers and husband. The goal for Resident (C) was to interact with staff, peers, and husband without being verbally aggressive. Approaches to the problem included, but were not limited to: "encourage resident to be busy in constructive manner, friendly and pleasant approach with smile, gently redirect resident away from</p>			

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	<p>person she is directing her aggression to, walking with resident outside and may try to redirect with conversation about her pet cat."</p> <p>During review of the Mood and Behavior weekly report, provided by the Administrator on 9/18/14 at 8:15 a.m., during the week of 7/11/14, Resident (C) was noted for wandering, pulling on blinds and pulling items off walls. On 7/14/14, Resident (C) broke the screen out of the dining room window. On 7/17/14, Resident (C) was noted to be agitated, wandering in and out of others' room and taking personal items and resisting care. Current interventions attempted were not effective; one on one, toileting, fluids and snacks.</p> <p>During the week of 7/22/14, Resident (C) was found pulling off wallpaper, removing clothing from her room and hanging the clothing in another resident's room and pouring baby powder in another resident's room. No interventions were noted.</p> <p>During the week of 8/8/14, Resident (C) was observed wandering in and out of other resident's room and stripped the bed. Resident (C) was sometimes easily redirected with the listed interventions; one on one and walking with resident.</p>			

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	<p>During the week of 8/27/14, Resident (C) was observed to have been wandering in and out of others' rooms and taking others' items. She was found with a full roll of toilet paper and the toilet paper wrapper was found in another resident's bathroom. Resident (C) was redirected several times but continued to be busy. The only intervention noted was; one on one.</p> <p>Progress notes, dated 9/17/14 at 3:19 p.m., indicated Resident (C) was walking with a CNA, when she walked up to another resident in the dining room and poked the resident on the left side of face.</p> <p>This Federal tag relates to Complaint IN00155848.</p> <p>3.1-45(a)(1)</p>			