| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED |
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| | 155243 | | 11/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SIGNATURE HEALTHCARE OF LAFAYETTE | 300 WINDY HILL DR<br>LAFAYETTE, IN 47905 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: November 17, 18, 19, 20, 23, and 24, 2015<br><br>Facility number: 000147<br>Provider number: 155243<br>AIM number: 100266900<br><br>Census bed type:<br>SNF/NF: 106<br>Total: 106<br><br>Census payor type:<br>Medicare: 15<br>Medicaid: 75<br>Other: 16<br>Total: 106<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality Review completed by 21662 on November 30, 2015. | F 0000 | Dear Ms Rhoades, Please accept the attached plan of correction as our allegation of compliance effective December 21, 2015 for our recertification survey that was completed on November 24, 2015. We respectfully request a desk review. I have included the educational information and audit tool for your review. Any additional documents can be made available to you for your review. If you have any questions, please feel free to contact me at 765-477-7791 ext 204 Best regards, Laurie Dotas, HFA CEO | |
| F 0278<br>SS=D<br>Bldg. 00 | 483.20(g) - (j)<br>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>The assessment must accurately reflect the resident's status. | | | |

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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| | A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) were accurately coded for 3 of 31 residents reviewed for accurate MDS assessments (Resident #85, Resident #97, and Resident #102).<br><br>Findings include:<br><br>1.) The clinical record of Resident #85 was reviewed on 11/20/15 at 10:20 a.m. Diagnoses included, but were not limited | F 0278 | F278 *It is the practice of Signature Healthcare of Lafayette to ensure assessments accurately reflect the residents status.*<br><br>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br><br>·For residents #85, #97 and | 12/21/2015 |

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| | to: Thyroid Disease, Diabetes, Anxiety, Blindness in the right eye, Pneumonia, Chronic Urinary Retention, Hypertension, Dementia, Unavoidable Weight loss due to end stage Dementia.<br><br>During resident observation on 11/19/15 at 9:30 a.m., Resident # 85 was observed to be edentulous (being without teeth).<br><br>The MDS assessment dated 8/22/15 was not marked as being edentulous.<br><br>2.) The clinical record of Resident #97 was reviewed on 11/20/15 at 10:00 a.m. Diagnoses included, but were not limited to: Hypertension, Back pain, Spinal stenosis, Weakness, History of Guillain-Barre, Paralysis, Muscle Spasms.<br><br>During resident observation on 11/18/15 at 2:55 p.m., Resident #97 was observed to have broken and missing teeth.<br><br>The MDS assessment dated 10/18/15 was not marked as having missing or broken teeth.<br><br>During an interview on 11/20/2015 1:39 p.m., with MDS #4 she indicated Resident #85 and Resident #97's dental status was marked inaccurately on the MDS assessment. | | #102, the MDS has been corrected to reflect the residents current status.<br><br>II. <u>How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?</u><br><br>Corrective Action includes:<br><br>·MDS's completed in the last 90 days for current residents will be reviewed to ensure the oral health and incontinence sections have been completed accurately. Changes will be made if issues are identified.<br><br>III <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u><br><br>·The MDS staff has been re-educated on the coding of the oral health section and incontinence sections.<br>·IDT will audit 30% of completed MDS's in morning meeting to ensure oral and incontinence status is accurate for one month then 15% for an additional two months. | |

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| | During an interview on 11/24/15 at 3:30 p.m., with the Chief Executive Officer, she indicated the facility did not have a policy related to MDS assessments. She indicated the facility follows the Resident Assessment Instrument (RAI) guidelines. | | IV. How will the corrective action be monitored to ensure the alleged deficient practice will not recur?<br><br>·Results of audits will be presented at Quality Assurance Committee (QA) on a quarterly basis until which time the QA Committee determines otherwise until a pattern of compliance has been established. .<br>·The QA Committee will make appropriate recommendations as indicated by the trends identified.<br><br>V. By what date will the systemic changes be completed?<br><br>-<br><br>Compliance date: December 21, 2015<br><br>-<br><br>December 21, 2015 and ongoing | |

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| F 0279<br>SS=D<br>Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | | | |
| | Based on record review and interview, the facility failed to develop a Plan of Care related to dental status for 2 of 3 residents reviewed for dental services (Resident #85 and Resident #97).<br><br>Findings include:<br><br>1.) The clinical record of Resident #85 was reviewed on 11/20/15 at 10:20 a.m.. Diagnoses included, but were not limited to: Thyroid Disease, Diabetes, Anxiety, Blindness in the right eye, Pneumonia, Chronic Urinary Retention, Hypertension, Dementia, Unavoidable | F 0279 | F279 *It is the practice of Signature Healthcare of Lafayette to use the results of the assessment to develop, review and revise the resident's comprehensive care plan*<br><br>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br><br>·For residents #85 and #97, the care plan was updated to reflect the residents being edentulous and/or broken and missing teeth. | 12/21/2015 |

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| | Weight loss due to end stage Dementia.<br><br>During resident observation on 11/19/15 at 9:30 a.m., Resident # 85 was observed to be edentulous (being without teeth).<br><br>The record lacked a plan of care related to the resident being edentulous.<br><br>2.) The clinical record of Resident #97 was reviewed on 11/20/15 at 10:00 a.m.. Diagnoses included, but were not limited to: Hypertension, Back pain, Spinal stenosis, Weakness, History of Guillain-Barre, Paralysis, Muscle Spasms.<br><br>During resident observation on 11/18/15 at 2:55 p.m., Resident #97 was observed to have broken and missing teeth.<br><br>The record lacked a plan of care for the broken and missing teeth.<br><br>During an interview on 11/20/2015 1:39 p.m., with MDS #4 she indicated Resident #85 and Resident #97's should have had a care plan in place.<br><br>During an interview on 11/24/15 at 3:30 p.m., with the Chief Executive Officer, she indicated the facility did not have a policy related to care plans. She indicated an interim care plan should be initiated | | II. How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?<br><br>Corrective Action includes:<br><br>·Resident care plans will be reviewed to ensure oral health care plans are in place.<br><br>III What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>·The MDS staff has been re-educated on care planning dental concerns and care.<br>·IDT will all review scheduled care plans weekly x one month then audit new admissions monthly x 2 months or until substantial compliance has been achieved.<br><br>IV. How will the corrective action be monitored to ensure the alleged deficient practice will not recur? | |

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| | when a resident was admitted to the facility and then the facility followed the Resident Assessment Instrument (RAI) guidelines.<br><br>3.1-35(a) | | ·Results of audits will be presented at Quality Assurance Committee (QA) on a quarterly basis until which time the QA Committee determines otherwise until a pattern of compliance has been established. .<br>·The QA Committee will make appropriate recommendations as indicated by the trends identified.<br><br>V. By what date will the systemic changes be completed?<br><br>-<br><br>Compliance date: December 21, 2015<br><br>-<br><br>December 21, 2015 and ongoing | |
| F 0428<br>SS=D<br>Bldg. 00 | 483.60(c)<br>DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | | | |

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| | The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br>Based on record review and interview the facility failed to ensure resident medication regimen was reviewed regularly for 1 of 5 residents reviewed for unnecessary medications. (Resident #134).<br><br>Findings include:<br><br>The clinical record of Resident #134 was reviewed on 11/20/15 at 2:00 p.m. Diagnoses included, but were not limited to Cardiovascular Disease with stents, lumbar radiculopathy, pulmonary edema, depression, and Diabetes Mellitus.<br><br>Medications included, but were not limited to, escitalopram (antidepressant), trazadone (hypnotic), humalog (insulin).<br><br>Pharmacy review reports for the months of September 2015, October 2015 and November 2015 indicated the medications for Resident #134 were not reviewed in October 2015.<br><br>During an interview with the Director of Nursing on 11/24/15 at 3:20 p.m., she indicated the pharmacist had no record of reviewing the medications for Resident | F 0428 | F428 *It is the practice of Signature Healthcare of Lafayette to ensure all current resident medications are reviewed by a pharmacist monthly.* I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br>·For Residents #134, the residents medication regime was reviewed on November 5, 2015.<br>II. How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?<br>Corrective Action includes:<br>·The November pharmacy report was reviewed to ensure all residents were reviewed. No discrepancies were found.<br>III What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br>·The pharmacy consultant will obtain a facility census upon entry the day of review to ensure the pharmacy roster is complete.<br>·The Director of Nursing and/or designee will review 100% of pharmacy reports monthly to ensure all residents were reviewed. Any discrepancies will | 12/21/2015 |

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| | #134 during the month of October. Resident was not out of the facility during the month of October.<br><br>A review of a policy titled "Consultant Pharmacist Services Provider Requirements" dated 10/07, indicated "...d. Medication Regimen Reviews (MMR)<br>for each Skilled Nursing (SNF) resident at least monthly, or more frequently under certain conditions, incorporating the federally mandated standards of care in addition to other applicable professional standards...."<br><br>3.1-25(h) | | be reported to the pharmacy consultant and review will be completed within five working days.<br>IV. How will the corrective action be monitored to ensure the alleged deficient practice will not recur?<br>·The Director of Nursing will present results of audits at Quality Assurance Committee (QA) on a quarterly basis until which time the QA Committee determines otherwise until a pattern of compliance has been established. .<br>·The QA Committee will make appropriate recommendations as indicated by the trends identified.<br>V. By what date will the systemic changes be completed?<br>Compliance date: December 21, 2015 December 21, 2015 and ongoing | |
| F 0441<br>SS=E<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual | | | |

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| | resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) 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.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, interview and record review, the facility failed to follow facility policy regarding the replacement and disposal of disposable drinking cups for 1 of 2 residents reviewed for hydration (Resident #151) and 2 of 9 additional residents reviewed for following the facility policy (Resident #100 and #101). The facility also failed to ensure new personnel were screened for tuberculosis using the two-step process for 1 of 5 new employees reviewed for tuberculosis testing (CNA #1). | F 0441 | F441 *It is the practice of Signature Healthcare of Lafayette to maintain a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.*<br><br>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?<br><br>·Use of the disposable cups has been discontinued per | 12/21/2015 |

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| | Findings include:<br><br>1. During an observation on 11/20/2015 at 2:48 p.m., Residents #151, #100, and #101 were observed to have ice water in a disposable cup at bedside. The cup for Resident #151 was dated 11/13/2015. Resident #100 and Resident #101 had cups dated 11/14/2015. There were no additional cups or pitchers of fluid observed in the rooms.<br><br>During an interview on 11/20/2015 at 3:08 p.m., Unit Manager #1 indicated disposable cups should have been changed out nightly.<br><br>During an interview on 11/23/2015 at 1:17 p.m., the Director of Nursing indicated the facility was in the process of switching over from the disposable cups to plastic water pitchers, but they did not have enough plastic pitchers for all residents at that time. Therefore, some residents were still using only disposable cups. She indicated the disposable cups should have been thrown away nightly and replaced and the plastic water pitchers should have been cycled through the dishwasher nightly.<br><br>A current policy, titled "Distributing Fresh Drinking Water," dated 06/01/2015, provided by the DON on | | resident request. Facility uses plastic water pitchers for resident ice water. Ice water is distributed each shift and upon request and pitchers switched out at night.<br>·C.N.A. #1 has received a two-step PPD.<br><br>II. How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?<br><br>Corrective Action includes:<br><br>·Resident rooms were searched to identify any remaining disposable cups. Those were discarded.<br>·All staff ppd's have been reviewed to ensure they have been completed per policy.<br><br>III What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>·The staff has been educated on ice water policy and procedure.<br>·SDC has been educated on two step ppd policy for new hires.<br>·ADON and/or designee will audit 25% of residents five days | |

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| | 11/23/2015 at 1:15 p.m., indicated, "...8. Drinking containers are refreshed each night and disposable containers from prior day discarded and new drinking containers given to resident...." | | per week to ensure ice water is being distributed per policy x 1 month, then twice weekly for month until a pattern of compliance has been established.<br>·Administrator will review all new hire ppd's monthly for 3 months until a threshold of 100% is achieved for three consecutive months.<br><br>IV. How will the corrective action be monitored to ensure the alleged deficient practice will not recur?<br><br>·Results of audits will be presented at Quality Assurance Committee (QA) on a quarterly basis until which time the QA Committee determines otherwise until a pattern of compliance has been established. .<br>·The QA Committee will make appropriate recommendations as indicated by the trends identified.<br><br>V. By what date will the systemic changes be completed?<br><br>-<br><br>Compliance date: December 21, 2015 | |

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| (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 |
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| | | | December 21, 2015 and ongoing | |
| F 0465<br>SS=E<br>Bldg. 00 | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure a clean, sanitary, and home-like environment related to 8 of 40 resident rooms and 2 hallway corridors (Room's # 111, 117, 121, 123, 132, 201, 215, 233).<br><br>Findings include:<br><br>1. During the initial tour on 11/17/2015 at 9:45 a.m., the following were observed:<br><br>a.) 3 pieces of cracked and broken trim in the corridor leading to Birchwood Hall.<br><br>b.) 2 pieces of cracked and broken trim in the corridor leading to Cedarwood Hall. | F 0465 | F465 *It is the practice of Signature Healthcare of Lafayette to*<br><br>*provide a safe, functional,*<br><br>*sanitary, and comfortable environment for*<br><br>*residents, staff and the public.*<br><br><u>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</u><br><br>·Rooms #111, #117, #121, #123, #132, #201, #215, #233 and the 2 hallway corridors had corrections/ repairs made during the survey. | 12/21/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 11/24/2015 |
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| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF LAFAYETTE | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DR LAFAYETTE, IN 47905 | |

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| | c.) A bent weather stripping on a service door leading to the Cedarwood Hall leaving a 1 inch gap between the ground and service door.<br><br>2. During resident room observations on 11/18/2015 and 11/19/2015, the following were observed:<br><br>a.) Room 111 on 11/19/2015 at 10:00 a.m., the bedroom walls were gouged and marred, the dresser was gouged and marred.<br><br>b.) Room 117 on 11/19/2015 at 10:34 a.m., the window sill was missing a large chunk of wood on the right hand corner.<br><br>c.) Room 121 on 11/19/2015 at 1:48 p.m., the window sills were chipped, gouged, and missing pieces on the left and right corners.<br><br>d.) Room 123 on 11/19/2015 at 9:55 a.m., the walls were marred and gouged behind both beds.<br><br>e.) Room 132 on 11/18/15 at 4:11 p.m., the walls were gouged and marred, closet trim was broken, loose, and not secure.<br><br>f.) Room 201 on 11/18/15 at 10:23 a.m., the lighting in the bathroom was dark and dim. | | II. How will other residents having the potential to be affected by the same alleged deficient practice be identified and what corrective action will be taken?<br><br>Corrective Action includes:<br><br>· Rounds have been completed on resident rooms and repairs have been completed.<br><br>III What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>·The staff has been re-educated with regards to completing work orders and maintenance staff has been educated on requirement of safe/ functional/ sanitary/ comfortable environment.<br>·PI tool has been developed that will identify safe/ functional/ sanitary and comfortable environment weekly x 4 and monthly x 3.<br><br>IV. How will the corrective action be | |

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| | g.) Room 215 on 11/19/15 at 11:18 a.m., the walls were gouged with a hole in the wall behind the bed, a leather chair was worn and in disrepair.<br><br>h.) Room 233 on 11/19/15 at 10:31 a.m., the bedroom walls were gouged and marred.<br><br>During an interview on 11/23/2015 at 10:15 a.m., the Director of Plant Operations indicated the facility had a reporting system for all staff to notify the Plant Department needed repairs. Work orders were turned in by staff or residents and the work was then scheduled by priority. The Director of Plant Operations indicated he was not aware of the facility needing these repairs.<br><br>During review of the facility policy titled " Work Order" dated 01/2005 received from the Director of Nursing on 11/23/15 at 1:15 p.m., the policy indicated "... Procedure... 2. It shall be the responsibility of the department directors or any staff member identifying needed repairs to fill out and forward such work to the maintenance director...4. Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily. 5. Emergency requests will be given | | monitored to ensure the alleged deficient practice will not recur?<br><br>·Results of audits will be presented at Quality Assurance Committee (QA) on a quarterly basis until which time the QA Committee determines otherwise until a pattern of compliance has been established. .<br>·The QA Committee will make appropriate recommendations as indicated by the trends identified.<br><br>V. By what date will the systemic changes be completed?<br><br>-<br><br>Compliance date: December 21, 2015<br><br>-<br><br>December 21, 2015 and ongoing | |

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| | priority in making necessary repairs...."<br><br>3.1-19(f) | | | |