

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/23/2012
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NAME OF PROVIDER OR SUPPLIER  ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F0000	<p>This visit was for the Investigation of Complaint IN00106502 and Complaint IN00107333.</p> <p>Complaint IN00106502 -- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00107333 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F425 and F514.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: April 20, 22 and 23, 2012</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 35 SNF/NF: 63 Residential 29 Total: 127</p> <p>Census payor type: Medicare: 34 Medicaid: 37 Other: 56</p>	F0000	<p><b>This plan of correction is to serve as Arbor Trace's credible allegation of compliance.</b></p> <p><b>Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b></p>	

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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	<p>Total: 127</p> <p>Sample: 4</p> <p>Supplemental Sample: 1</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/30/12 by Suzanne Williams, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician medication orders were transcribed correctly and then, subsequently administered correctly for 1 of 4 residents in a sample of 4 reviewed for pharmacy services. (Resident #B)</p> <p>Findings include:</p> <p>Review of Resident #B's clinical record was conducted on 4-20-12 at 5:20 a.m. It indicated she was admitted to the facility on 4-8-12. Her diagnoses included, but were not limited to, left hip replacement on 4-5-12, high blood pressure and diabetes.</p> <p>Review of her admission orders from her physician included lisinopril/hydrochlorothiazide 10/12.5 milligrams (mg) (prescription medication to treat high blood pressure) 0.5 (one-half) tablet by mouth daily. This medication was transcribed by the facility as, "lisinopril/hydrochlorothiazide 10/12.5 mg...1 tablet oral...once a day." This medication was documented on the</p>	F0282	<p><b>F282 483.20 (k) (3) (iii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p><b>I. Resident B no longer resides in the community</b></p> <p><b>II. All medication orders were verified to be transcribed correctly during a facility wide physician order audit. All residents on sliding scale insulin have been identified. Sliding scale orders have been reviewed to determine they are transcribed correctly.</b></p> <p><b>III. The licensed nursing staff has been educated on transcription of new orders. The systemic change includes that all new medication orders will be verified by two nurses upon transcription.</b></p> <p><b>IV. The DON/Designee will audit all medication administration records for proper transcription including sliding scale insulin administration. This review will be done for 100% new medication orders 3 times a week for 8 weeks. Following this initial 8 weeks, random</b></p>	05/07/2012			

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	<p>Medication Administration Record (MAR) as administered on April 9th through April 20th, 2012.</p> <p>Another admission order from her physician included Humalog insulin for a sliding scale insulin administration, based on blood sugar (BS) readings twice daily to be administered subcutaneously (injection under the skin) twice daily after meals. The sliding scale was indicated to be administered as follows: BS 0-150: 0 units (of Humalog insulin) BS 151-200: 1 unit BS 201-250: 2 units BS 251-300: 3 units 301-350: 4 units 351-399: 5 units.</p> <p>This medication was transcribed by the facility as follows: Humalog insulin 100 units/ml (milliliter), administer as sliding scale subcutaneous BID-twice a day: "0-150=0 units, 151-200=1 unit, 201-250=3 units, 251-300=4 units, 301-350=4 units, 351-399=5 units." The MAR indicated this sliding scale was used to administer the Humalog insulin for elevated blood sugars on 4-11-12 at 9:00 a.m. for a blood sugar of 292 and the resident received 4 units; on 4-11-12 at 1:00 p.m. for a blood sugar of 239 and received A policy entitled, "Medication Administration: General Policies and Procedures," with an attestation date of 3-27-12 was provided by the Administrator on 4-23-12 at 10:50</p>		<p><b>review of a minimum of 5 MARs will occur on each of the 6 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits to determine that medications are provided as ordered by the physician.</b></p> <p><b>COMPLIANCE DATE: 5/7/2012</b></p>				

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	<p>a.m. This document indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so." 3 units; on 4-13-12 at 1:00 p.m. and received 4 units; 4-14-12 at 1:00 p.m. and received 3 units.</p> <p>In interview with LPN #3 on 4-20-12 at 6:22 a.m., she indicated, "It looks like there is an error with the lisinopril/hydrochlorothiazide order and the sliding scale insulin order...Looks like [name of medical director]'s usual sliding scale order got entered into the system."</p> <p>A policy entitled, "Transcribing Orders," was provided by the Director of Nursing on 4-20-12 at 9:15 a.m. This policy indicated, "Physician orders will be transcribed to dedicated medical records timely, completely and accurately using acceptable standards of practice...Must be accurate. Orders should be written as given by the physician. If unclear, clarify with the physician after writing...Must be complete. Medication orders require: drug, dosage, route of administration and frequency of administration...Drug doses that have ranges require special attention."</p> <p>A policy entitled, "Medication</p>						

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	<p>Administration: General Policies and Procedures," with an attestation date of 3-27-12 was provided by the Administrator on 4-23-12 at 10:50 a.m. This document indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...All medications are to be administered only as prescribed by a physician..."</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<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 interview and record review, the facility failed to provide care and services to relieve pain in a timely manner, which resulted in the resident being in pain and resulted in the resident leaving the facility against medical advice. This affected 1 of 4 residents in a sample of 4 reviewed for pain, pharmacy services and assessment (Resident #D).</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 4-23-12 at 9:25 a.m. It indicated he was admitted to the facility on 4-12-12 at 5:29 p.m. His diagnoses included, but were not limited to, pyelonephritis (kidney infection), MRSA (methicillin-resistant staphylococcus aureus, a bacteria) in the urine, severe spinal stenosis (back problems), chronic kidney disease, prostate disorder, ischemic heart disease, chest pain, high blood pressure and diabetes.</p> <p>An "Admission/Readmission Nursing</p>	F0309	<p><b>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p><b>Facility disagrees with this citation and is requesting the informal dispute resolution procedure.</b></p> <p><b>I. Resident #D no longer resides in the community.</b></p> <p><b>II. The facility will complete a 100% audit to determine residents are receiving medications as ordered. Any issues identified will be corrected immediately.</b></p> <p><b>III. The systemic change includes that all medication orders will be faxed to pharmacy timely and in addition the pharmacy will be called for all orders that occur for newly admitted patients and patients returning with new orders. The EDK (Emergency Drug Kit) will be utilized when needed for first dose of new drug order when</b></p>	05/07/2012			

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	<p>Assessment," was completed on 4-13-12 at 1:54 a.m. by LPN #1. This assessment document indicated the resident was able to make himself understood and was able to understand others. It indicated he was alert and his short term memory and long term memory was "OK." It indicated the resident complained of back pain. Progress notes did not indicate he received any pain medication for the back pain or the last time that he had received pain medication prior to admission to the facility. This assessment document did not indicate a pain assessment was conducted.</p> <p>The admission orders from the physician for Resident #D indicated he could have Hydrocodone/APAP 7.5/500 milligrams (mg) one tablet by mouth every 6 hours as needed for pain.</p> <p>A progress note, dated 4-13-12 at 2:14 a.m. by LPN #1, indicated, "Resident just left ama [against medical advice] at this time. Attempted to talk to resident and family members numerous times."</p> <p>The next progress note on 4-13-12 at 6:28 a.m. [sic] by LPN #2 indicated, "CNA came to nurse stating the resident was requesting his medicine at this a.m. [sic] I said that the residents [sic] medicine had not came [sic] in yet and that I would talk</p>		<p><b>the drug is available in the EDK. The after hours pharmacy system will be utilized for new orders that occur after hours if the drug is not in the EDK. Education will be provided to licensed nurses to include:</b></p> <ul style="list-style-type: none"> <li>· Procedure to fax and call pharmacy for new admits/readmits or needed medication and the systemic changes described above.</li> <li>· Use of the EDK</li> <li>· Importance of timely drug administration</li> <li>· Notifying DON or administrative nurse when medications are not available</li> </ul> <p><b>IV. DON/Designee will audit through review of MARs(Medication Administration Records). This review will be done for 100% new medication orders 3 times a week for 8 weeks. Following this initial 8 weeks, random review of a minimum of 5 MARs will occur on each of the 5 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits to determine that medications are provided as ordered by the physician. COMPLIANCE DATE: 5/7/2011</b></p>		

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	<p>to him. I went to resident's room and introduced myself to him stating that I was his nurse and I asked him if I could help him with anything. He stated to me that he had been in pain since he arrived. He then stated that he had been requesting pain medicine and that he was being told that it hadn't come in yet. I told him I would check to see what pain pill he was on and see if we had it in our EDK [emergency drug kit] and call pharmacy to give it to him. He told me that it was too late and that he was in too much pain. He also stated that he was already off schedule for his meds. He refused for me to take his vitals [vital signs]. He stated for me to leave the light on and that he was calling his son. He called his son and told him to come and pick him up, and that he was not happy with the service here."</p> <p>Progress notes did not indicate Resident #D had requested pain medication for any purpose. They did not indicate the resident's medications had been ordered from the pharmacy for him.</p> <p>In interview with LPN #1 on 4-23-12 at 10:10 a.m., she indicated she had checked on Resident #D several times on the evening of his admission, 4-12-12. She indicated he said he was comfortable. She indicated, "To be honest, I did not</p>			

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	<p>check the EDK to see if any of his meds were there because I had been told his meds were statted [sent as a priority by the pharmacy]. She indicated she had been told this by the evening shift supervisor around 8:30 p.m. She indicated around 10:30 p.m., one of the CNAs had told her and the on-coming night shift nurse the resident was complaining of pain. She did not indicate if she went to check on the resident at that time in order to assess his level of pain. She indicated the resident's medication did not arrive until around 1:00 a.m. on 4-13-12. She indicated she was unfamiliar with the facility's EDK that stored narcotic medications, only aware of the ones that had oral medications and the EDK for antibiotics. She indicated when the medications did arrive "around 1:00 a.m.," she prepared them and took them to his room and did not find the resident in his room. She indicated the staff immediately began looking for the resident. She indicated the resident's son met the staff in the hallway and informed them his father was "in his truck." She indicated she and the son tried to talk him into remaining at the facility to no avail. She indicated the resident refused the medications she had prepared.</p> <p>In interview with LPN #2 on 4-22-12 at 4:11 a.m., she indicated when she came</p>			

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	<p>on duty on 4-12-12 at 10:00 p.m., to relieve LPN #1, LPN #1 was down the hall completing her medication pass. She indicated LPN #1 did not complete this task until around 11:15 p.m. She indicated at this time, she received the shift report from LPN #1. She indicated during the shift report she was informed the facility was awaiting Resident #D's medication, but did not mention he was experiencing any pain. She indicated after report, she began her midnight medication pass. She indicated at approximately 12:45 a.m. on 4-13-12, a CNA told her that Resident #D "was very upset and wanted to know if his medications were in." She indicated she then went to check on the resident. She indicated, "He was very upset, said he had been asking for his meds since he got here. Said he was leaving. Told me twice he was calling his son and was very unhappy with our services. Told me there was nothing I could do to help him...I asked the nurse [LPN #1] if she had pulled the meds from the EDK, if his narcotics were in the EDK and [if] she got the codes from the pharmacy. She told me she did not have the time to do that, that was the first thing out of her mouth. After [name of Resident #D] left, then she said she didn't know the process to use the EDK."</p>			

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	<p>In review of LPN #1's employee record, it indicated she was hired by the facility on 2-23-12. In interview with LPN #1 on 4-23-12 at 10:10 a.m., she indicated she had been a nurse since 1998. The facility's "Job Specific Orientation - Charge Nurse," was unavailable. In interview with the Director of Nursing (DON) on 4-23-12 at 11:26 a.m., she indicated the facility did not have this document back from LPN #1, as the staff member has 90 days from date of hire to return it completed to the facility. The DON provided a blank copy of this document on 4-23-12 at 3:05 p.m. It did not list specific training for the EDK. However, it did indicate training topics which included, "Reorder/check in meds received...Admission process/assessments...Use/charting of PRN [as needed] medications...Processing admissions &amp; discharges...Ancillary supplies: charging system; inventory, and ordering."</p> <p>In interview with the facility's Corporate Nurse on 4-23-12 at 11:50 a.m., she indicated she had worked with LPN #1 at another long term care facility previously. She indicated in LPN's most recent position prior to being employed at this facility had been as the staff development person. She indicated, "She was the one who trained new staff...she was aware of</p>						

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	<p>EDK's and how they worked."</p> <p>In interview with the facility's medical director on 4-23-12 at 12:45 p.m., he indicated he had worked with LPN #1 at the facility she had worked at prior to employment at this facility for approximately 10 years. He indicated she was the staff development person at that facility. He indicated, "There is no way she wouldn't be familiar with EDK's...All she would have had to do was call me and I would have called the pharmacy for an authorization code and within 20 minutes the problem would be taken care of."</p> <p>A policy entitled, "Emergency Drug Supply," with an attestation date of 3-27-12, was provided on 4-23-12 at 10:50 a.m. This policy indicated the facility's pharmacy provider, "Provides an emergency supply medications [sic] commonly used in the facility. The emergency medications are to be used by the facility when a medication is not present in the facility and it is deemed necessary to initiate medication prior to the next scheduled medication delivery from the pharmacy...Emergency controlled substances are kept in a locked container within a locked storage area on the nursing unit."</p> <p>A listing of the narcotics available in the</p>				

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	<p>EDK was provided by the DON on 4-23-12 at 10:50 a.m. This listing indicated the pain medication ordered for as needed pain relief, Hydrocodone/APAP 7.5 milligrams (mg)/ 325 mg (also known as Norco) was available in the narcotic EDK for the facility. The DON demonstrated the location of this particular EDK on 4-23-12 at 4:08 p.m. as the lock box of the medication cart for the "Private Hall."</p> <p>This Federal tag relates to Complaint IN00107333.</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155481		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/23/2012	
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F0514 SS=D	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure physician orders were properly transcribed, complete and accurate for 2 of 4 residents reviewed for pharmacy services and accurate documentation in a sample of 4. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. Review of Resident #B's clinical record was conducted on 4-20-12 at 5:20 a.m. It indicated she was admitted to the facility on 4-8-12. Her diagnoses included, but were not limited to, left hip replacement on 4-5-12, high blood pressure and diabetes.</p> <p>Review of her admission orders from her physician included lisinopril/hydrochlorathiazide 10/12.5</p>	F0514	<p><b>F514 483.75 (I) (1) RES RECORDS-COMplete/ACCUR ATE/ACCESSIBLE I. Residents B and C no longer reside in the community. II. All medication orders were verified to be transcribed correctly during a facility wide physician order audit. All residents on sliding scale insulin have been identified. Sliding scale orders have been reviewed to determine they are transcribed correctly. All therapy orders have been verified to have stop dates. III. The licensed nursing staff has been educated on transcription of new orders. The therapy staff has been educated on stop dates for therapy orders. The systemic change includes that all new medication orders will be verified by two nurses upon</b></p>	05/07/2012			

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	<p>milligrams (mg) (prescription medication to treat high blood pressure) 0.5 (one-half) tablet by mouth daily. This medication was transcribed by the facility as, "lisinopril/hydrochlorothiazide 10/12.5 mg...1 tablet oral...once a day." This medication was documented on the Medication Administration Record (MAR) as administered on April 9th through April 20th, 2012.</p> <p>Another admission order from her physician included Humalog insulin for a sliding scale insulin administration, based on blood sugar (BS) readings twice daily to be administered subcutaneously (injection under the skin) twice daily after meals. The sliding scale was indicated to be administered as follows: BS 0-150: 0 units (of Humalog insulin); BS 151-200: 1 unit; BS 201-250: 2 units; BS 251-300: 3 units; 301-350: 4 units; 351-399: 5 units. This medication was transcribed by the facility as follows: Humalog insulin 100 units/ml (milliliter), administer as sliding scale subcutaneous BID-twice a day: "0-150=0 units, 151-200=1 unit, 201-250=3 units, 251-300=4 units, 301-350=4 units, 351-399=5 units."</p> <p>The MAR indicated this sliding scale was used to administer the Humalog insulin for elevated blood sugars on 4-11-12 at</p>		<p><b>transcription.</b></p> <p><b>IV. The DON/Designee will audit all medication administration records and therapy orders for proper transcription. This review will be done for 100% new medication and therapy orders 3 times a week for 8 weeks. Following this initial 8 weeks, random review of a minimum of 5 MARs and 5 new therapy orders will occur on each of the 5 units (total of 30 records) weekly for 16 weeks, and then monthly for an additional 6 months to total 12 months of audits to determine that medications are provided as ordered by the physician.</b></p> <p><b>COMPLIANCE DATE: 5/7/2012</b></p>		

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	<p>9:00 a.m. for a blood sugar of 292 and the resident received 4 units; on 4-11-12 at 1:00 p.m. for a blood sugar of 239 and received 3 units; on 4-13-12 at 1:00 p.m. and received 4 units; 4-14-12 at 1:00 p.m. and received 3 units.</p> <p>In interview with LPN #3 on 4-20-12 at 6:22 a.m., she indicated, "It looks like there is an error with the lisinopril/hydrochlorothiazide order and the sliding scale insulin order...Looks like [name of medical director]'s usual sliding scale order got entered into the system."</p> <p>2. Resident #C's clinical record was reviewed on 4-20-12 at 5:58 a.m. She was admitted to the facility on 4-6-12. Her diagnoses included, but were not limited to, low back pain, requiring parenteral opiates (injectable narcotic pain control), anxiety, and lumbo-sacral (low back) canal stenosis.</p> <p>Review of her admission orders from her physician indicated she was to receive tramadol 50 mg (non-narcotic pain reliever) every 6 hours as needed for pain by mouth. This medication order was indicated to be transcribed by the facility as tramadol 50 mg one tablet as needed. This transcription did not indicate the frequency in which the medication could be given. This medication was</p>				

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	<p>documented in the MAR as given once on 4-11-12.</p> <p>Another physician order, dated 4-9-12 with no time indicated, "OT [occupational therapy] Clarification: OT eval[uation] complete. Tx [therapy] recommended for 5x[times]/wk[week] x ____ [blank line] wks...."</p> <p>In interview with LPN #3 on 4-20-12 at 6:50 a.m., she indicated the tramadol order should specify how often it can be given. She indicated the therapy order should list the number of weeks in the order instead of leaving it blank.</p> <p>A policy entitled, "Transcribing Orders," was provided by the Director of Nursing on 4-20-12 at 9:15 a.m. This policy indicated, "Physician orders will be transcribed to dedicated medical records timely, completely and accurately using acceptable standards of practice...Must be accurate. Orders should be written as given by the physician. If unclear, clarify with the physician after writing...Must be complete. Medication orders require: drug, dosage, route of administration and frequency of administration...Drug doses that have ranges require special attention."</p> <p>A policy entitled, "Medication</p>				

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	<p>Administration: General Policies and Procedures," with an attestation date of 3-27-12, was provided by the Administrator on 4-23-12 at 10:50 a.m. This document indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...All medications are to be administered only as prescribed by a physician...."</p> <p>This Federal tag relates to Complaint IN00107333.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			