

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F0000	<p>This visit was for the Investigation of Complaints IN00119369 and IN00124049.</p> <p>Complaint IN00119369- Substantiated. Federal/state deficiency related to the allegations is cited at F323</p> <p>Complaint IN00124049- Substantiated. Federal/state deficiencies related to the allegation are cited at F250 and F514.</p> <p>Survey dates: February 11, 12, & 13, 2013</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF: 24 SNF/NF: 103 Residential: 40 Total: 167</p> <p>Census payor type: Medicare: 19 Medicaid: 86</p>	F0000		

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>Other: 62 Total: 167</p> <p>Sample: 13</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 18, 2013, by Janelyn Kulik, RN.</p>				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to follow their policy and procedures related to the documentation of behaviors for 2 of 3 resident's reviewed for behaviors in the sample of 13. (Residents #B & #M)</p> <p>Findings include:</p> <p>1. The closed record for Resident #B was reviewed on 2/12/13 at 10:30 a.m. The resident was admitted to the facility on 10/23/12. The resident's diagnoses included, but were not limited to, advanced dementia, high blood pressure, diabetes mellitus, and anxiety.</p> <p>Review of the 10/30/12 Minimum Date Set (MDS) admission assessment indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident had displayed physical behaviors directed towards others, verbal behaviors towards others, and other behaviors. The assessment also indicated the</p>	F0250	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. By 3/8/13 issues related to behavior management documentation will be corrected with implementation of Point Click Care. b. Behavior logs no longer utilized with the implementation of Point Click Care. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken: a. Residents on antipsychotic medication as well as those exhibiting behaviors will have a computerized assessment for behavior completed by 3/8/13 and quarterly thereafter.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Social Service was in-serviced by administrator on 2/26/13 to establish a plan of care called "Behavioral Symptom Assessment" as soon as notified, and on all residents with psychotropic Medication orders. b. Nursing staff will be re-educated by nursing</p>	03/08/2013			

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	<p>behaviors interfered with the resident's care and participation in activities and social interactions. The assessment also indicated the resident rejected care.</p> <p>A care plan initiated on 10/24/12 indicated the resident had behaviors of yelling and hitting at staff members. Care plan interventions included for staff to observe the resident for anxiety and assist to quiet area if indicated, have a different staff member re-approach the resident, request assistance from family for support, medicate with Ativan (an medication to treat anxiety) if all other approaches are ineffective.</p> <p>The 10/2012 Behavior Tracking Form listed the resident's behaviors as yelling, resisting care, and hitting at staff. All of the above behaviors were listed on the same sheet. The form indicated one entry was made on 10/26/12 on the 7:00 a.m.- 3:00 p.m. shift The entry noted the behavior occurred once. The form did not indicate the type of behavior the resident displayed on the above shift.</p> <p>The 10/26/12 Nurses' Notes were reviewed. The only day shift entry was made on 10/26/12 at 11:00 a.m. The entry indicated the resident had</p>		<p>management/designee on Behavioral Notes by 3/8/13. The Behavior notes are found within Point Click Care. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. Social Service will monitor/audit Monday through Friday all records of residents exhibiting behaviors or on psychotropic medication to ensure that continued compliance is obtained. b. The monitoring/audit will be done Monday through Friday for one month on each nursing unit by social service personnel, and then two times per week for two months and then once weekly for the remaining three months, for a total of six months. c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted quarterly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review. d. All reports of monitoring/audits will be reported to the Quality Assurance meeting monthly for six months deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued</p>		

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	<p>no behaviors.</p> <p>The 11/2012 Behavior Tracking Form listed the resident's behaviors as yelling, resisting care, striking at staff, and was fearful and suspicious. All of the above behaviors were listed on the same sheet. The form indicated the resident displayed behaviors on the following days/shifts:</p> <p>11/1/12 x2 on the day shift x2 on the evening shift</p> <p>11/2/12 x2 on the night shift</p> <p>11/3/12 x1 on the evening shift</p> <p>11/4/12 x2 on the day shift and x2 on the night shift x1 on the evening shift</p> <p>11/5/12 x1 on the day and x1 on the evening shift</p> <p>11/6/12 x1 on the evening shift</p> <p>11/7/12 x2 on the day shift x1 on the evening shift x3 on the night shift</p> <p>11/10/12 x2 on the day shift x1 on the evening shift</p> <p>11/11/12 x2 on the day shift</p>		<p>monitoring until corrections are effective.</p>				

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	<p>11/12/12 x2 on the evening shift 11/17/12 x2 on the day shift 11/24/12 x2 on the night shift The above entries did not specify the type of behavior the resident exhibited at the above times.</p> <p>The 11/2012 Nurse' Notes were reviewed. On 11/1/12 an entry was made at 9:30 a.m. which indicated the resident had refused to return from therapy. There were no further entries of the any further behaviors on the day shift. On 11/1/12 there was only one entry made on the evening shift. This entry was made at 7:30 p.m. and indicated when trying to provide care the resident yelled out. On 11/10/12 the only entry made for the evening shift was at 4:00 p.m. There was no documentation of the resident displaying any behaviors in this entry.</p> <p>The 12/2012 Behavior Tracking Form listed the resident's behaviors as yelling, resisting care, striking at staff, and was fearful and suspicious. All of the above behaviors were listed on the same sheet. The form indicated the resident displayed behaviors on the following days/shifts:</p>						

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	<p>12/2/12 x1 on the day shift</p> <p>12/5/12 x2 on the evening shift</p> <p>12/7/12 x1 on the day shift</p> <p>x1 on the evening shift</p> <p>12/9/12 x1 on the evening shift</p> <p>12/10/12 x1 on day shift</p> <p>x1 on the evening shift</p> <p>The form did not indicate the type of behaviors the resident exhibited on the above dates.</p> <p>The 12/2012 Nurses' Notes were reviewed. There was only one entry made on 12/2/12. This entry was made at 6:00 p.m. There was no documentation of any resident behaviors in the entry.</p> <p>When interviewed on 2/13/13 at 11:40 a.m., the Alzheimer Unit Director indicated there was only one monthly log for each resident. The Director indicated the log listed types of the behaviors the resident was known to have. The Director indicated the log did list the number of behaviors the resident displayed but did not specify which of the listed behaviors the resident was displaying with each incident. The Director</p>						

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	<p>indicated there should be documentation of the specific behaviors the resident's are having.</p> <p>2. The record for Resident # M was reviewed on 2/12/13 at 12:30 p.m. The resident's diagnosis included, but were not limited to, depression, Alzheimer's disease, high blood pressure, and anemia. The resident was admitted to the facility in 10/2/12. The resident resided on the locked Dementia unit.</p> <p>Review of the 12/31/12 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive patterns were severely impaired.</p> <p>A care plan initiated on 10/3/12 indicated the resident exhibit wandering with poor safety awareness. Care plan interventions included for staff to approach the resident in a slow and calm manner, assess the resident's needs, redirect from the area with diversional activity or conversation, and reorient the resident to facility landmarks such as his room.</p> <p>A care plan initiated on 12/18/12 indicated the resident displayed anger with staff, hitting and cursing</p>			

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	<p>when care is given, and was resistant to care. Care plan interventions included to have a different staff member approach the resident, explain the need for assist, remove the resident from the situation is possible, use the recliner in the day room, or offer to take the resident to visit his wife on another unit in the facility.</p> <p>Review of the 12/2012 Behavior Tracking Form indicated the resident's behaviors were listed as being resistive to care by hitting staff and calling them names. The form indicated the resident displayed a behavior x1 on the evening 12/18/12 evening shift. The form also indicated the resident displayed a behavior on the 12/19/12 day shift. The form did not indicate the type of behavior the resident displayed at the above times.</p> <p>The 12/2012 Nurses' Notes were reviewed There was one entry made on 12/18/12. This entry was made at 4:00 p.m. There was no documentation of the resident displaying any behaviors. There was one entry made on the day shift on 12/19/12. This entry was made at 1:55 p.m. There was no documentation of the resident displaying any behaviors in this entry.</p>			

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	<p>Review of the 1/2013 Behavior Tracking Form indicated the resident's behaviors were listed as being resistive to care by hitting staff and calling them names. The form indicated the resident had behaviors three times on the evening shift on 1/7/13. The type of behavior was not listed on the entry.</p> <p>The current facility policy titled "Behavior Management" was reviewed on 2/13/13 at 11:15 a.m. The policy had a revised date of 12/8/11. The policy was provided by the Nurse Consultant. The policy indicated behavioral monitoring logs were to be implemented. The policy also indicated staff were to document assessment of resident's exhibiting behavior symptoms in the resident's medical record.</p> <p>When interviewed on 2/13/13 at 11:40 a.m., the Alzheimer Unit Director indicated there was only one monthly log for each resident. The Director indicated the log listed types of the behaviors the resident was known to have. The Director indicated the log did list the number of behaviors the resident displayed but did not specify which of the listed behaviors the resident was displaying</p>						

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	<p>with each incident. The Director indicated there should be documentation of the specific behaviors the residents were having.</p> <p>This federal tag relates to Complaint IN00124049.</p> <p>3.1-34(a)(1)</p>				

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F0323 SS=G	<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, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to transferring a resident with assistance and assistive devices per the resident's plan of care for 1 of 3 residents reviewed for fractures in the sample of 13. This deficient practice resulted in an ankle fracture. (Resident #C) (CNA #3)</p> <p>Finding include:</p> <p>On 2/12/13 at 10:00 a.m., CNA #1 and CNA #2 were observed transferring Resident #C from the bed into a recliner chair in her room. The resident was transferred using a mechanical left. There was a dressing on the resident's right ankle area.</p> <p>The record for Resident #C was reviewed on 2/12/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, congestive</p>	F0323	<p>It is the practice of this provider to ensure residents are provided care in a manner and in an environment that maintains or enhances each resident's dignity.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice a. Resident "C" had been assessed by the IDT immediately following the incident. b. Resident "C" was sent to the hospital for evaluation and treatment 12/3/12 c. Plan of care was updated for upon return to address the resident's safety needs.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:a. Residents with a history of falls and/or at high risk for falls have the potential to be affected. The IDT will assess residents to determine fall risk potential and develop plan of care to address residents current safety needs as appropriate. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:a. Nursing staff</p>	03/08/2013			

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	<p>heart failure, depression, high blood pressure, arthritis, and obesity.</p> <p>Review of the 1/2/13 Orthopedic Physician Progress Note indicated the resident had sustained a fracture of the right ankle four weeks ago and surgery was completed to repair the fracture.</p> <p>Review of the 10/3/12 Minimum Data Set (MDS) significant change assessment indicated the resident required extensive assistance of two or more staff members for transfers.</p> <p>Review of the 12/2012 Physician orders indicated there was an order written on 12/3/12 to send the resident to the hospital Emergency Room for an evaluation related to a fall.</p> <p>Review of the 2/2013 Physician Order Statement indicated the resident was not to ambulate or bear weight on the right leg.</p> <p>The 12/2012 Nurses' Notes were reviewed. An entry made on 12/3/12 at 10:30 a.m., indicated the Nurse was called to the resident's room and observed the resident lying in a supine position on the floor. The entry also indicated a deformity to the</p>		<p>was re-educated by nursing administration on 12/3/12 regarding use of gait belt and care card.b. Nursing staff was re-educated by nursing administration on 12/28/12 on proper use of Mechanical Lift.c. Nursing staff was re-educated by nursing administration by 3/8/13 regarding use of gait belt, care card and proper use of mechanical lift.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place. a. DON/Designee staff will monitor/audit during routine rounds to ensure that continued compliance is obtained. b. The monitoring will be done daily, Monday through Friday for one month on each nursing unit, and then two times per week for two months and then once weekly for the remaining three months. c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted quarterly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review. d. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee</p>		

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	<p>right ankle with active bleeding was observed. The entry also indicated the resident complained of pain and rated the pain at a severity level of ten based on a scale of one to ten. An entry made at 10:50 a.m. indicated the Paramedics arrived at the facility and the resident was transferred to the hospital at 11:00 a.m.</p> <p>An "Incident and Accident Report" dated 12/3/12 was received from the Director of Nursing and reviewed 2/12/13 at 2:00 p.m. The report indicated Resident #C was transferred from a bedside commode to a recliner, became dizzy, and fell to the floor. The report indicated a deformity to the resident's right ankle was observed and the resident was sent to the hospital.</p> <p>An "Investigation Conclusion" form was attached to the above "Incident and Accident Report". The form indicated the Nurse observed the resident lying on the floor in the supine position. The form also indicated blood and a deformity were noted to the right ankle. The form also indicated the IDT (Inter Disciplinary Team) determined the cause of the fall was related to a CNA not utilizing a gait belt and not having assistance</p>		will develop plan of action to correct and recommend continued monitoring until corrections are effective.				

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	<p>when transferring the resident.</p> <p>The resident's care plan and care card were also attached to the above "Incident and Accident Report." A care plan initiated on 10/5/12 indicated the resident was at risk for falls related to a history of a fall, obesity impairing mobility, and a history of stating "My knees give out." Care plan interventions included staff to transfer the resident with a full mechanical lift if the resident felt weak, dizzy, or fatigued. The care card indicated the resident was to be transferred with two assist and a gait belt was to be used when transferring the resident.</p> <p>When interviewed on 2/12/13 at 2:35 p.m., the Director of Nursing indicated CNA #3 transferred the resident from the bed to the bedside commode and then when transferring the resident from the bedside commode to the chair the resident started to get up and fell. The Director of Nursing indicated Resident #C was to be transferred with the assistance of two staff members and the staff were to use a gait belt when transferring the resident. The Director of Nursing indicated the resident stood up with the CNA standing next to her and the CNA turned to move the bedside</p>				

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	<p>commode and the resident fell. The Director of Nursing indicated the CNA transferred the resident by herself and did not use a gait belt as per the resident's plan of care.</p> <p>This federal tag relates to Complaint IN00119369.</p> <p>3.1-45(a)(2)</p>			

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F0514 SS=D	<p>483.75(l)(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 record review and interview the facility failed to ensure clinical records were accurate and complete related to documentation of personal property on the Inventory List upon discharge from the facility for 3 of 4 closed records reviewed in the sample of 13. (Residents #B, #D, & #E)</p> <p>Findings include:</p> <p>1. The closed record for Resident #B was reviewed on 2/12/13 at 10:30 a.m. The resident was admitted to the facility on 10/23/12. The resident's diagnoses included, but were not limited to, advanced dementia, high blood pressure, diabetes mellitus, and anxiety. The resident was transferred to a hospital</p>	F0514	<p>It is the policy of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Residents related to this citation are no longer residing within the facility2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. All newly admitted residents as well as returning residents have the potential to be affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. The nursing staff will be re-educated by 3/8/12 on the proper</p>	03/08/2013			

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	<p>on 12/13/12. The resident returned to the facility on 12/27/12. The resident expired on 12/28/12.</p> <p>Review of the Inventory List form indicated the form was signed by the resident's family member on 10/23/12 upon admission to the facility. The sections titled "Items Brought in at Admission" and "Items Acquired After Admission" were not completed. Written papers with only clothing items described were with the form. No items were listed on the form. On the bottom of the form "per social services family took belongings 12/30/12" was hand written.</p> <p>When interviewed on 2/13/13 at 2:25 p.m., the facility Administrator indicated the Inventory Forms should be completed upon admission and discharge including listing all items upon admission, those acquired during stay, and at the time of discharge, including listing items and signatures.</p> <p>2. The closed record for Resident #D was reviewed on 2/13/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, arthritis, and constipation. The resident was sent to the hospital on 1/12/13 and did not</p>		<p>completion of personal property inventory sheets. b. All current residents will have personal inventory sheets completed and in the clinical record by 3/8/13.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. that quality assurance program will be put into place.</p> <p>a. DON/Designee staff will monitor/audit during routine rounds to ensure that new admissions and re-admissions have completed, signed sheets within 72 hours of their admission/re-admission to the facility. . b. The monitoring will be done Monday through Friday for six months.. c. The monitoring/audits will be submitted to the Quality Assurance Committee and continue to be conducted quarterly to assure continued compliance with staff knowledge and competency of the policies until the compliance is maintained as determined by the Quarterly Assurance Committee review. d. Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plan of action to correct and recommend continued monitoring until corrections are effective.</p>		

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	<p>return to the facility.</p> <p>Review of the Inventory List form indicated the form was signed by the resident's family member on 10/28/11 upon admission to the facility. The sections titled "Items Brought in at Admission" and "Items Acquired After Admission" were not completed. Written papers with only clothing items described were with the form. No items were listed on the form. There were no staff signatures on the form. There was no documentation to indicate the disposition of any of the resident's belongings upon discharge from the facility.</p> <p>When interviewed on 2/13/13 at 2:25 p.m., the facility Administrator indicated the Inventory Forms should be completed upon admission and discharge including listing all items upon admission, those acquired during stay, and at the time of discharge, including listing items and signatures.</p> <p>3. The closed record for Resident #E was reviewed on 2/12/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, high blood pressure, anemia, and diabetes mellitus. The</p>				

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	<p>resident was admitted to the facility on 8/10/10. The resident was sent to the hospital on 10/20/12 and did not return to the facility.</p> <p>Review of the Inventory List form indicated the form was signed by the resident's family member on 8/13/10 upon admission to the facility. Two items and a bookcase were listed on the section titled "Items Brought in at Admission" and no items were listed under the "Items Acquired After Admission" section. Written papers with only clothing items described were with the form. No items were listed on the form. On the bottom of the form "10/20/12 per social service, all belongings picked up by daughter..." was hand written. There were no staff signatures on the form.</p> <p>The current facility policy titled "Discharge of a Resident" was received from the Nurse Consultant on 2/13/13 at 2:20 p.m. The policy was last revised on 12/14/11. The policy indicated staff were to complete the personal property inventory including items in the resident's room and have the resident or the responsible party sign in the appropriate area. The policy also indicated staff assisting were to sign the form.</p>						

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	<p>When interviewed on 2/13/13 at 2:25 p.m., the facility Administrator indicated the Inventory Forms should be completed upon admission and discharge including listing all items upon admission, those acquired during stay, and at the time of discharge, including listing items and signatures.</p> <p>This federal tag relates to Complaint IN00124049.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			