

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/28/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 5480 E 25TH ST COLUMBUS, IN 47203
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F0000	<p>This visit was for the Investigation of Complaint IN00103346.</p> <p>Complaint IN00103346 - Substantiated. Federal/state deficiencies related to the allegation are sited at F225 and F226.</p> <p>Survey dates: February 27 and 28, 2012</p> <p>Facility number: 000284 Provider number: 155424 AIM number: 100290690</p> <p>Survey team: Jill Ross, RN, TC Diana Sidell, RN</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 1 Medicaid: 32 Other: 2 Total: 35</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exist or that one is cited correctly. This plan of correction is submitted to meet the requirements by state and federal law. Hickory Creek at Columbus desires this plan of correction to be considered the facility's allegation of compliance. Compliance is effective March 15, 2012.</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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	Quality review completed on March 2, 2012 by Bev Faulkner, RN				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>A. Based on record review and interview, the facility failed to ensure an alleged</p>	F0225	F225  It is the policy and standard of	03/15/2012			

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	<p>occurrence of abuse witnessed by 2 CNAs was reported immediately to the Administrator and other state officials and failed to insure the protection of the residents by not suspending the RN pending their investigation. This affected 1 of 2 residents reviewed for allegations of abuse in a sample of 4. (Resident A)</p> <p>B. Based on record review and interview the facility failed to timely report a fall with injury. This affected 1 of 2 residents reviewed for allegations of abuse in a sample of 4. (Resident A)</p> <p>Findings include:</p> <p>A. Resident A's record was reviewed on 2/27/12 at 10:35 a.m. The record indicated Resident A was admitted with diagnoses that included but were not limited to dementia, high blood pressure, right hip fracture, and osteopenia (weakening of the bones).</p> <p>A quarterly Minimum Data Set assessment, dated 2/17/12, indicated Resident A was severely cognitive impaired - never/rarely made decisions in cognitive skills for daily decision making, required extensive assistance of 2 or more persons for transfers and ambulation, was only able to maintain balance with assistance, used a walker or a wheelchair,</p>		<p>practice that this facility reports allegations of abuse to the Administrator immediately and to appropriate state agencies as required; in addition, this facility insures the protection of residents from those alleged to have been involved in the possible abuse situation.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>1. The Administrator was not made aware of the alleged incident for Resident A until January 20, 2012 at which time the incident was reported to ISDH. This incident was reported to the Director of Operations via telephone by the Director of Nursing Services, 18 days after the incident allegedly occurred. At the time of the reporting the Director of Nursing Services was on suspension for violation of Hickory Creek policy, including failure to report allegations timely. An investigation was immediately initiated. Based upon the elapsed time involved the RN was not placed on suspension. The results of the incident were inconclusive as there was conflicting information given by employees who were on duty at the time the incident occurred. The RN denies the bath blanket was "tied around the waist". It was placed around the resident for warmth and was actually placed on the resident by a CNA,</p>				

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	<p>and has had falls with major and minor injuries since admission.</p> <p>An incident report was provided by the Administrator on 2/27/12 at 3:30 p.m. The Administrator indicated she had e-mailed the initial incident report on 1/20/12 to the ISDH and the follow-up report on 1/27/12. The Administrator provided a copy of the e-mail transmission, dated 1/27/12, but was unable to provide a copy of the 1/20/12 e-mail transmission for this incident. The Administrator stated this was reported late because she did not find out about it until she was doing her incident audit on 1/20/12. She also stated that "it may have been reported to my DON (Director of Nursing) at the time of the incident but I did not know about it until my review."</p> <p>This incident report included but was not limited to "Brief Description of Incident: It has been reported that on the evening of 1/2/12 [Resident A] was tied to her wheel chair with a bath blanket by [RN #1]. According to the nurse's notes from this evening [Resident A] was agitated from 6:00 PM - 10:00 PM. Type of Injury/Injuries: no known injuries. Immediate Action Taken: Investigation implemented. Staff members have been interviewed who worked that evening and the facility administration is getting</p>		<p>but at no time was it tied.</p> <p>1. This incident involving Resident A did not involve abuse but rather a fall that required the resident to have sutures. This incident was mistakenly not reported to ISDH when it occurred, but when the Administrator realized the error it was reported.</p> <p>All employees will be re-in-serviced on the facility Abuse Protocol to include but not be limited to the residents' rights to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to engage in or allow verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion by March 15, 2012.</p> <p>Employees will be reminded during these in-services that the Administrator must be made aware of any allegation of abuse immediately. This includes calling the Administrator at home if needed, regardless of the time of day.</p> <p>All employees will be re-inserviced on the facility's Reportable Policy and Procedure to include guidelines of reportable occurrences which include any</p>		

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	<p>conflicting reports of what occurred. Investigation will continue...Results of Investigation: [CNA #1] and [CNA #2] through interview have stated that [RN #1] tied a bath blanket around [Resident A] during one of their shifts, but could not recall the exact date. [CNA #1] states she worked from 4:00 PM - 8:00 P.M. that night. Through review of the schedule it has been concluded this event took place on January 2, 2012. [CNA #1] states when she clocked out at 8:00 P.M. that evening [Resident A] was sitting at the nurse's station with a bath blanket tied around her waist. [CNA #2] reports the same incident. [CNA #2] worked until 10:00 P.M. that evening...Based on conflicting stories of what concurred that evening it can not be concluded if this event took placed (sic). The resident is not interviewable...All staff received inservice on Preventing, Recognizing and Reporting Elder Abuse during the month of January...Even though it is not concluded that this incident occurred, [RN#1] will receive a written reprimand."</p> <p>Interviews of staff were done 1/20/12 to 1/27/12.</p> <p>No indication that RN #1 was suspended pending this investigation was documented in the incident report.</p>		<p>type of abuse and any type of laceration that requires sutures.</p> <p>All employees will be re-in-serviced on the faculty's Restraint Policy and Procedure to include when a restraint can be placed and what an appropriate restraint is and who has the authority to initiate the restraint. During these re-in-services, staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, or involuntary seclusion including the use of an improper restraint must be reported immediately to the Administrator.</p> <p>Any employee who has an allegation made against him/her will be immediately suspended pending an investigation regardless of the employee's denial of the incident.</p> <p>A newly hired Director of Nursing will start at the facility on March 26, 2012. As part of his orientation, he will receive the same information regarding allegations of abuse and restraint use that is discussed in the employee in-services outlined under question #1. In addition, the Administrator will direct him as to her expectations for his follow up and reporting issues, such as suspected abuse, to her immediately.</p>		

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	<p>Review of the time clock record for RN #1 indicated she worked 12 hour shifts on the following dates: 1/20/12, 1/21/12, and 1/22/12. This was after the Administrator indicated awareness of the incident.</p> <p>On 2/27/12 at 3:54 p.m., the Administrator indicated RN #1 was not suspended following the allegation of her tying Resident A in her wheelchair.</p> <p>A Pre-Restraining Assessment with dates of 12/12/11 and 1/6/12 indicated there was to have been a "lap buddy on the wheelchair while resident is up in wheelchair." There was no mention of a lap buddy being used on the wheelchair at the time of the alleged incident.</p> <p>B. A review of an entity self reported incident dated as received on 1/31/12 at 11:12 a.m., at ISDH indicated "1. Brief Description on Incident: During review of January 2012 incident reports it was discovered this incident was not reported - Resident A fell from her wheelchair on 1/5/12 - personal safety alarm sounded &amp; staff found resident on floor laying face down w/ (with) her wheelchair behind her. 2. Type of Injury: 5 cm laceration to face. 3. Immediate action taken: laceration cleansed &amp; pressure applied -</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>- All residents have the potential to be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, with behavioral symptoms and totally dependent residents and those who are at risk for falls. There were no other residents identified as being affected by these practices.</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>- The Director of Nursing will review the 24 hour report, focus charting, and any incident reports when he reports for work on each tour of duty. He will also review any allegations of abuse, making sure that the Administrator has been informed of the allegations and that the staff involved has been suspended pending investigation. He will bring all of this information, including any allegations of abuse to the next scheduled morning interdisciplinary management meeting that meets at least 5 days a week for review. The Administrator will determine whether or not the incident/accident meets reportable guidelines by the</p>		

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	<p>three steri strips applied - ambulance services contacted for transportation to ER - 12 sutures received - resident was returned to facility. 4. Preventive measures taken: Care plan updated - Resident A had lap buddy placed on wheelchair - all previous interventions have been continued."</p> <p>In interview with the Administrator on 2/27/12 at 3:54 p.m., she indicated the incident did meet their criteria for reporting an unusual occurrence. "I thought it had been reported by someone but it had not been, so I went ahead and reported it."</p> <p>A policy and procedure for "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property" was provided by the Administrator on 2/27/12 at 9:37 a.m. The policy indicated but was not limited to "Standard: Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion...J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported</p>		<p>Administrator. If the incident does meet the guidelines, it will be reported to ISDH within 24 hours of the incident time.</p> <p>In addition, the Administrator will begin the investigation for any allegation of abuse, directing those managers who are to be involved in the investigation itself. The results of the investigation will be finalized by the Administrator and reported to the State Department of Health within the required time frame.</p> <p><u>4. How will the corrective action be monitored to ensure the deficient practice doe not recur and what QA will be put into place?</u></p> <p>- The Administrator and Director of Nursing will bring all incidents, including allegations of abuse, for review during the monthly QA meeting. Any recommendations made by the QA Committee will be followed through by the Administrator, who will then report the result of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis.</p> <p>Date of Compliance: March 15, 2012</p>				

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	<p>per state and federal law (typically within 24 hours of witness/identification)...All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process...L. Protection: resident/families alleging abuse, neglect, or misappropriation of property are to be protected during the investigation. Included in the protective measures are:</p> <p>1. Immediate suspension of the individual accused of the alleged neglect, abuse, misappropriation of resident property, pending the outcome of the investigation of the alleged abuse...."</p> <p>This federal tag relates to Complaint IN00103975.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>A. Based on record review and interview, the facility failed to implement their policy and procedure related to reporting and protecting a resident after an allegation of abuse. This affected 1 of 2 residents reviewed for allegations of abuse in a sample of 4. (Resident A)</p> <p>B. Based on record review and interview, the facility failed to implement their policy and procedure related to the reporting of an incident after a resident fell and sustained a laceration 5 cm long which required 12 sutures. This affected 1 of 2 residents reviewed for allegations of abuse in a sample of 4. (Resident A)</p> <p>Findings include:</p> <p>A. Resident A's record was reviewed on 2/27/12 at 10:35 a.m. The record indicated Resident A was admitted with diagnoses that included but were not limited to dementia, high blood pressure, right hip fracture, and osteopenia (weakening of the bones).</p>	F0226	<p>F226 It is the policy and standard of practice that this facility reports allegations of abuse to the Administrator immediately and to appropriate state agencies as required; in addition, this facility insures the protection of residents from those alleged to have been involved in the possible abuse situation. <u>1. What corrective action will be done by the facility?</u></p> <p>1. The Administrator was not made aware of the alleged incident for Resident A until January 20, 2012 at which time the incident was reported to ISDH. This incident was reported to the Director of Operations via telephone by the Director of Nursing Services, 18 days after the incident allegedly occurred. At the time of the reporting the Director of Nursing Services was on suspension for violation of Hickory Creek policy, including failure to report allegations timely. An investigation was immediately initiated. Based upon the elapsed time involved the RN was not placed on suspension. The results of the incident were inconclusive as there was conflicting information given by</p>	03/15/2012	

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	<p>A quarterly Minimum Data Set assessment, dated 2/17/12, indicated Resident A was severely cognitive impaired - never/rarely made decisions in cognitive skills for daily decision making, required extensive assistance of 2 or more persons for transfers and ambulation, was only able to maintain balance with assistance, used a walker or a wheelchair, and has had falls with major and minor injuries since admission.</p> <p>An incident report was provided by the Administrator on 2/27/12 at 3:30 p.m. The Administrator indicated she had e-mailed the initial incident report on 1/20/12 to the ISDH and the follow-up report on 1/27/12. The Administrator provided a copy of the e-mail transmission, dated 1/27/12, but was unable to provide a copy of the 1/20/12 e-mail transmission for this incident. The incident occurred on 1/2/12 but was not reported or investigated until 1/20/12. The Administrator stated she did not find the incident until 1/20/12 when she was doing an incident audit. She stated "it may have been reported to my DON (Director of Nursing) at the time but I didn't know about it until the audit."</p> <p>This incident report included but was not limited to "Brief Description of Incident: It has been reported that on the evening of</p>		<p>employees who were on duty at the time the incident occurred. The RN denies the bath blanket was "tied around the waist". It was placed around the resident for warmth and was actually placed on the resident by a CNA, but at no time was it tied.</p> <p>1. This incident involving Resident A did not involve abuse but rather a fall that required the resident to have sutures. This incident was mistakenly not reported to ISDH when it occurred, but when the Administrator realized the error it was reported.</p> <p>All employees will be re-in-serviced on the facility Abuse Protocol to include but not be limited to the residents' rights to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion and misappropriation of resident property and that employees of this facility are not to engage in or allow verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion by March 15, 2012. Employees will be reminded during these in-services that the Administrator must be made aware of any allegation of abuse immediately. This includes calling the Administrator at home if needed, regardless of the time of day. All employees will be re-in-serviced on the facility's</p>				

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	<p>1/2/12 [Resident A] was tied to her wheel chair with a bath blanket by [RN #1]. According to the nurse's notes from this evening [Resident A] was agitated from 6:00 PM - 10:00 PM. Type of Injury/Injuries: no known injuries. Immediate Action Taken: Investigation implemented. Staff members have been interviewed who worked that evening and the facility administration is getting conflicting reports of what occurred. Investigation will continue...Results of Investigation...[CNA #1] and [CNA #2] through interview have stated that [RN #1] tied a bath blanket around [Resident A] during one of their shifts, but could not recall the exact date. [CNA #1] states she worked from 4:00 PM - 8:00 P.M. that night. Through review of the schedule it has been concluded this event took place on January 2, 2012...Based on conflicting stories of what concurred that evening it can not be concluded if this event took placed (sic). The resident is not interviewable...All staff received inservice on Preventing, Recognizing and Reporting Elder Abuse during the month of January...Even though it is not concluded that this incident occurred, [RN#1] will receive a written reprimand."</p> <p>No indication that RN #1 was suspended pending this investigation was documented in the incident report.</p>		<p>Reportable Policy and Procedure to include guidelines of reportable occurrences which include any type of abuse and any type of laceration that requires sutures. All employees will be re-in-serviced on the faculty's Restraint Policy and Procedure to include when a restraint can be placed and what an appropriate restraint is and who has the authority to initiate the restraint. During these re-in-services, staff will be reminded that any allegation of verbal, sexual, physical and mental abuse, corporal punishment, or involuntary seclusion including the use of an improper restraint must be reported immediately to the Administrator. Any employee who has an allegation made against him/her will be immediately suspended pending an investigation regardless of the employee's denial of the incident. A newly hired Director of Nursing will start at the facility on March 26, 2012. As part of his orientation, he will receive the same information regarding allegations of abuse and restraint use that is discussed in the employee in-services outlined under question #1. In addition, the Administrator will direct him as to her expectations for his follow up and reporting issues, such as suspected abuse, to her immediately. <u>2. How will the facility identify other residents having the potential to be affected</u></p>				

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	<p>Review of the time clock record for RN #1 indicated she worked 12 hour shifts on the following dates: 1/20/12, 1/21/12, and 1/22/12. This was after the Administrator indicated awareness of the incident.</p> <p>On 2/27/12 at 3:54 p.m., the Administrator indicated RN #1 was not suspended following the allegation of her tying Resident A in her wheelchair.</p> <p>B. A review of an entity self reported incident dated as received on 1/31/12 at 11:12 a.m., at ISDH indicated "1. Brief Description on Incident: During review of January 2012 incident reports it was discovered this incident was not reported - Resident A fell from her wheelchair on 1/5/12 - personal safety alarm sounded &amp; staff found resident on floor laying face down w/ (with) her wheelchair behind her. 2. Type of Injury: 5 cm laceration to face. 3. Immediate action taken: laceration cleansed &amp; pressure applied - three steri strips applied - ambulance services contacted for transportation to ER - 12 sutures received - resident was returned to facility. 4. Preventive measures taken: Care plan updated - Resident A had lap buddy placed on wheelchair - all previous interventions have been continued."</p>		<p><u>by the same practice and what corrective action will be taken?</u> _All residents have the potential to be affected, but particularly those residents with dementia, who are confused, unable to freely communicate, with behavioral symptoms and totally dependent residents and those who are at risk for falls. There were no other residents identified as being affected by these practices. <u>3. What measures will be put into place to ensure this practice does not recur?</u> _The Director of Nursing will review the 24 hour report, focus charting, and any incident reports when he reports for work on each tour of duty. He will also review any allegations of abuse, making sure that the Administrator has been informed of the allegations and that the staff involved has been suspended pending investigation. He will bring all of this information, including any allegations of abuse to the next scheduled morning interdisciplinary management meeting that meets at least 5 days a week for review. The Administrator will determine whether or not the incident/accident meets reportable guidelines by the Administrator. If the incident does meet the guidelines, it will be reported to ISDH within 24 hours of the incident time. In addition, the Administrator will begin the investigation for any</p>		

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	<p>In interview with the Administrator on 2/27/12 at 3:54 p.m., she indicated the incident did meet their criteria for reporting an unusual occurrence. "I thought it had been reported by someone but it had not been, so I went ahead and reported it."</p> <p>A policy and procedure for "Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property" was provided by the Administrator on 2/27/12 at 9:37 a.m. The policy indicated but was not limited to "Standard: Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion...J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of witness/identification)...All allegations will be thoroughly investigated and measures will be taken to prevent further potential abuse while the investigation is in process...L. Protection: resident/families alleging abuse, neglect, or misappropriation of property are to be</p>		<p>allegation of abuse, directing those managers who are to be involved in the investigation itself. The results of the investigation will be finalized by the Administrator and reported to the State Department of Health within the required time frame. <u>4. How will the corrective action be monitored to ensure the deficient practice doe not recur and what QA will be put into place?</u> The Administrator and Director of Nursing will bring all incidents, including allegations of abuse, for review during the monthly QA meeting. Any recommendations made by the QA Committee will be followed through by the Administrator, who will then report the result of those recommendations at the next scheduled QA meeting. This will continue on an ongoing basis. Date of Compliance: March 15, 2012</p>				

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	<p>protected during the investigation. Included in the protective measures are: 1. Immediate suspension of the individual accused of the alleged neglect, abuse, misappropriation of resident property, pending the outcome of the investigation of the alleged abuse...."</p> <p>This federal tag relates to Complaint IN00103975</p> <p>3.1-28(a)</p>			