

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00198687.</p> <p>Complaint IN00198687 - Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Survey date: May 5 and 6, 2016</p> <p>Facility Number: 000310 Provider Number: 155443 AIM number: 100288970</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 5 Medicaid: 41 Other: 5 Total: 51</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on May 9, 2016.</p>	F 0000	000 Preparation and or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This POC is to serve as the Waters of Muncie's credible allegation of compliance.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
F 0223 SS=G Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 3 of 5 residents interviewed regarding abuse. (Resident B , Resident C and Resident D)</p> <p>This deficient practice affected 3 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. The clinical record for Resident D was reviewed on 5/6/16 at 9:33 a.m. Diagnoses included, but were not limited to, dementia with behaviors, major depressive disorder, diabetes type II and hypertension.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/5/16, was reviewed on 5/5/16 at 9:33 a.m. The MDS indicated Resident D was moderately cognitively impaired. Resident D was a resident on the memory</p>	F 0223	<p><b>F-223</b> The waters of Muncie requests a face to face IDR for further discussion It is the policy of the facility to ensure that residents are free from verbal abuse. Resident D is redirected and their care planis followed as indicated by staff utilizing professional speech andactions. Resident D is not told by staffto go to their room if that is not Resident D's desire. Resident B and ResidentC are cared for in a professional manner by staff who use professional speechand actions. Based on facility wideinterviews of interviewable residents, no residents in the facility feel threatenedor fearful of any of the care givers employed by the facility. LPN #14 no longer isemployed by the facility. Residents who reside inthe facility had the potential to be affected by the finding. The DON/Designee or the Social ServicesDesignee will make rounds on various days and shifts (including some week</p>	05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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	
	<p>care unit.</p> <p>Review of an incident report, dated 4/19/16, indicated Resident D was yelling and attempting to hit a resident and staff members. LPN #14 approached Resident D and said "you can't hit people, it's a crime and you could go to jail".</p> <p>Review of the investigation performed by the facility noted two written statements from staff members who witnessed the incident. The written statements read as follows: CNA #5 "On April 19th the nurse (name of LPN #14) told a resident that he as going to call the police for her hitting another resident and he pretended he called them. He told her when she goes to jail she will be eating cold green bologna. He told her to wait in her room till [sic] the police came. She said no, she is waiting out here." The written statement was dated 4/20/16. CNA #6 "Heard nurse (name of LPN #14) tell (Resident D's name) that she can't hit people. (Resident D's name) called him a couple of names. He stated to (Resident D's name) I can hear you yelling down the hallway. It's a crime to hit someone and she can be arrested. He told her that he was calling the police. He pretended to call the police. She yelled call the police [sic]. She looked</p>		<p>enddays/shifts) at which time interviewable residents or the families ofnon-interviewable residents will be interviewed using CMS Form 20050 to assessfor any concerns related to staff treatment of the residents. There will be 10 residents/familiesinterviewed 3 days weekly. Any concernswill be addressed immediately as found. These interviews will continue until 4 consecutive weeks of zeronegative findings are achieved. After that, 10residents/families will be interviewed weekly for a period of not less than 6months to ensure ongoing compliance. Afterwards, random monitoring will occur ongoing. At an in-service held forall staff on 5-18-16 the following was reviewed: A.) AbusePolicy-Emphasis on reporting protocol of notifying the Administrator/Designee immediately of anyallegation of abuse so that further actions/ notifications/reportingcan be directed and carried out timely as per policy and regulation B.) Resident Rights C.) Dignity D.) Customer Service Note: All newly hired are in-serviced on the AbusePolicy upon hire. Any staff who fail tocomply with the points of the in-service will be further educated and/or progressively disciplinedas indicated. At the monthly QAmeetings, the results of the interviews will be discussed. However, any</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>around and said will where are they [sic]. He said you have [sic] give them a minute. I just called them. She said I wait for them [sic]. (Resident D's name) sat in a chair in the dining room. He said go wait for the police in your room. This took place at 8:55 pm 4/19/16. In front of other residents and staff."</p> <p>During an interview on 5/5/16 at 2:28 p.m., CNA #5 indicated the following: "(Name of LPN #14) told a resident he was going to call the police on her and pretended to call 911. He told her she would be eating cold green bologna sandwiches in jail." CNA #5 indicated LPN #14 was intimidating Resident D and felt it was verbal abuse so she reported it.</p> <p>Review of the incident investigation noted a statement form the Assistant Director of Nursing (ADON). The ADON's statement indicated LPN #14 had "no recollection of any events or statements that would have or could have been perceived as harmful towards the resident." The ADON's statement also noted CNA #5 indicated that LPN #14's "tone and wording were inappropriate."</p> <p>Review of the investigation report noted a statement signed by the Director of Nursing (DON) in which LPN #14 was</p>		concerns will have been addressed as found, including any necessary education and/or disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>given disciplinary action "related to professionalism and conversations inappropriate towards residents and in a work setting".</p> <p>During an interview on 5/5/16 at 4:55 p.m. CNA #4 indicated approximately one week ago a resident reported to her that (name of LPN #14) "got smart with her about something". CNA #4 indicated the resident complained about his attitude and tone of voice. CNA #4 indicated she asked LPN #14 about the incident and it was denied. CNA #4 never reported this to anyone else.</p> <p>During an interview on 5/6/16 at 11:04 a.m., the Administrator indicated LPN #14 was direct and could appear negative to the residents. "He is direct and I think some of the residents don't understand that." The Administrator also indicated LPN #14 was currently suspended pending investigation of the allegation of verbal abuse towards Resident B.</p> <p>2. The clinical record for Resident C was reviewed on 5/6/16 at 10:27 a.m. The diagnoses included, but were not limited to, paraplegia, spinal stenosis, diabetes type II, hypertension and anxiety.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/15/16,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>was reviewed on 5/6/16 at 10:27 a.m. The MDS indicated Resident C was cognitively intact.</p> <p>During an interview on 5/5/16 at 5:18 p.m., Resident C indicated she had been spoken to roughly by a nurse who was no longer allowed to work the memory care unit. Resident C stated "I get two insulin shots at night. (Name of LPN #14) brought in one shot and when I asked about the other shot he asked me 'Are you a nurse?'. I just let it go and 30 minutes later he wakes me up for another shot." Resident C indicated she did not report this incident because she did not feel anything would be done.</p> <p>3. The clinical record for Resident B was reviewed on 5/5/16 at 3:40 p.m. Diagnoses included, but were not limited to, anemia, diabetes type II, hypertension, major depressive disorder and atrial fibrillation.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/16/16, was reviewed on 5/5/16 at 3:40 p.m. The MDS indicated Resident B was cognitively intact.</p> <p>During an interview on 5/5/16 at 2:48 p.m., Resident B alleged LPN #14 had been verbally abusive to her on more than</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>one occasion. Resident B stated the following: "(Name LPN #14) works the afternoon shift 3-11. He hollered at me 3-4 months ago. He gets so mad he's like a red faced bull comin' at ya." Resident B indicated she had reported this incident to another nurse but could not recall who she reported it to. Resident B also indicated the same nurse had verbally abused her recently (the other night). "I get my own stuff at night like my washcloths and towels. I like to do for myself if I can. One night I got a pillowcase and I unfolded it to see what it was, you know make sure it's what I wanted. He came at me with his face all red. I thought he was going to hit me. He started yelling and I never even got to tell him what I was doing. I just came back to my room. He scares me." Resident B indicated she had not reported this incident to anyone. This incident was reported to the Administrator.</p> <p>Review of a current policy dated 7/1/11, titled "Abuse Prohibition" was provided by the Administrator on 5/5/16. This current policy indicated the following:</p> <p>"Guideline: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subjected to such events by anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the resident, family members or legal guardians friends or other individuals. This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain resident.</p> <p>1. Definitions of key terms:</p> <p>a) Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident , or visitor-to-resident.</p> <p>b) Verbal Abuse: The use of oral,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
F 0225 SS=D Bldg. 00	<p>written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability...."</p> <p>This federal tag relates to Complaint IN00198687.</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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	
	<p>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>Based on record review, and interview, the facility failed to ensure facility policy was implemented related to an allegation of staff to resident verbal abuse. This deficient practice affected 3 of 3 residents reviewed for abuse. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 5/6/16 at 9:33 a.m.</p>	F 0225	<p><b>F-225</b></p> <p>It is the policy of the facility to ensure that residents are free from verbal abuse. Part of the policy mandates immediate reporting of any alleged abuse to the Administrator/Designee so that they can see that further actions/reporting/notifications are carried out timely as per</p>	05/19/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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	
	<p>Diagnoses included, but were not limited to, dementia with behaviors, major depressive disorder, diabetes type II and hypertension.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/5/16, was reviewed on 5/5/16 at 9:33 a.m. The MDS indicated Resident D was moderately cognitively impaired. Resident D was a resident on the memory care unit.</p> <p>Review of an incident report, dated 4/19/16, indicated Resident D was yelling and attempting to hit a resident and staff members. LPN #14 approached Resident D and said "you can't hit people, it's a crime and you could go to jail".</p> <p>Review of the investigation performed by the facility noted two written statements from staff members who witnessed the incident. The written statements read as follows: CNA #5 "On April 19th the nurse (name of LPN #14) told a resident that he as going to call the police for her hitting another resident and he pretended he called them. He told her when she goes to jail she will be eating cold green bologna. He told her to wait in her room till [sic] the police came. She said no, she is waiting out here." The written</p>		<p>policy and regulation. This would include verifying resident safety, any necessary suspensions as well as initiation of an investigation.</p> <p>Any resident who resides in the facility has the potential to be affected by this finding. Going forward, the Administrator/Designee will report any allegation of abuse timely and as per policy and regulation. As part of the daily CQI meeting agenda, any event that appears on the 24 Hour Report review or any event that has been reported to the Administrator since the last daily CQI meeting that meets the criteria for abuse or alleged abuse will be reviewed to see that all protocol was followed including timely reporting to the ISDH. Any concerns will be immediately acted upon.</p> <p>(See agenda for all staff in-service for F-223 as education for F-225 is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>statement was dated 4/20/16.</p> <p>CNA #6 "Heard nurse (name of LPN #14) tell (Resident D's name) that she can't hit people. (Resident D's name) called him a couple of names. He stated to (Resident D's name) I can hear you yelling down the hallway. It's a crime to hit someone and she can be arrested. He told her that he was calling the police. He pretended to call the police. She yelled call the police [sic]. She looked around and said will where are they [sic]. He said you have [sic] give them a minute. I just called them. She said I wait for them [sic]. (Resident D's name) sat in a chair in the dining room. He said go wait for the police in your room. This took place at 8:55 pm 4/19/16 [sic]. In front of other residents and staff."</p> <p>During an interview on 5/5/16 at 2:28 p.m., CNA #5 indicated Resident D was in the hallway and another resident touched her walker. CNA #5 indicated Resident D did not like having her possessions touched and struck out at the other resident. CNA #5 intervened and Resident D then attempted to hit CNA #5 but she was able to avoid being hit. CNA #5 also indicated the following: "(Name of LPN #14) told the resident he was going to call the police on her and pretended to call 911. He told her should would be eating cold green</p>		<p>included).</p> <p>At the monthly QA meetings all Reportable Incidents since the previous QA meeting will be reviewed for timeliness of reporting. Any necessary action/education and/or progressive discipline will take place or will have taken place as indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>bologna sandwiches in jail." CNA #5 indicated LPN #14 was intimidating Resident D and felt it was verbal abuse. CNA #5 indicated she reported this incident to the third shift nurse.</p> <p>During an interview on 5/6/16 at 2:09 p.m., LPN #13 indicated she received information on the allegation from the third shift nurse when she reported for the day shift on 4/20/16. The third shift nurse had not reported the allegation to the Administrator or the Director of Nursing. LPN #13 stated she reported the allegation to the Assistant Director of Nursing (ADON) because the Administrator and the DON were at a conference and not present in the facility.</p> <p>During an interview on 5/6/16 at 11:04 a.m., the Administrator indicated she was made aware of the allegation on 4/20/16 and that she should have been notified the evening of 4/19/16. The Administrator indicated she instructed the ADON to suspend LPN #14 pending investigation and sent in the reportable to the State based on the information she was provided. The Administrator indicated she was told LPN #14 had allegedly verbally abused Resident D. The Administrator was aware there were two witnesses and requested the ADON to obtain statements from both of them.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>Review of a current policy, dated 7/1/11, titled "Abuse Prohibition" was provided by the Administrator on 5/5/16. This current policy indicated the following:</p> <p>"Guideline: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subjected to such events by anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the resident, family members or legal guardians friends or other individuals. This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for certain resident.</p> <p>1. Definitions of key terms: a) Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident , or visitor-to-resident.</p> <p>b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability...."</p> <p>Review of a current policy, dated 7/1/11, titled "Abuse Reporting" was provided by the Administrator on 5/5/16. This current policy indicated the following:</p> <p>"Guideline: It is the intent of the facility to encourage and support all residents, staff, and family members feel free to report any suspected acts of abuse, neglect, involuntary seclusion, or misappropriation of resident property. The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
F 0226 SS=D Bldg. 00	<p>Procedure: 1. Any person(s) witnessing or having knowledge of potential or actual abuse must contact and report the incident to the Administrator immediately. In the event the Administrator is unavailable, such report is to be made to the Administrator's Designee or the Charge Nurse who is responsible to follow through with reporting procedures...."</p> <p>This federal tag relates to Complaint IN00198687.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure facility policy was implemented when the staff identified an allegation of verbal abuse of a resident (Resident D). This deficient</p>	F 0226	It is the policy of the facility to follow the Abuse Policy and to see that it is implemented appropriately and timely as indicated.	05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>practice affected 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 5/6/16 at 9:33 a.m. Diagnoses included, but were not limited to, dementia with behaviors, major depressive disorder, diabetes type II and hypertension.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/5/16, was reviewed on 5/5/16 at 9:33 a.m. The MDS indicated Resident D was moderately cognitively impaired with a BIMS (Brief Interview for Mental Status Score) of 11. Resident D is a resident on the memory care unit.</p> <p>Review of an incident report dated 4/19/16 indicated Resident D was yelling and attempting to hit a resident and staff members. LPN #14 approached Resident D and said "you can't hit people, it's a crime and you could go to jail".</p> <p>Review of the investigation performed by the facility noted two written statements from staff members who witnessed the incident. The written statements read as follows: CNA #5 "On April 19th the nurse (name</p>		(See responses to F-223 and F-225 as responses for F-228 are included in the responses for those findings).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>of LPN #14) told a resident that he as going to call the police for her hitting another resident and he pretended he called them. He told her when she goes to jail she will be eating cold green bologna. He told her to wait in her room till [sic] the police came. She said no, she is waiting out here." The written statement was dated 4/20/16.</p> <p>CNA #6 "Heard nurse (name of LPN #14) tell (Resident D's name) that she can't hit people. (Resident D's name) called him a couple of names. He stated to (Resident D's name) I can hear you yelling down the hallway. It's a crime to hit someone and she can be arrested. He told her that he was calling the police. He pretended to call the police. She yelled call the police [sic]. She looked around and said will where are they [sic]. He said you have [sic] give them a minute. I just called them. She said I wait for them [sic]. (Resident D's name) sat in a chair in the dining room. He said go wait for the police in your room. This took place at 8:55 pm 4/19/16 [sic]. In front of other residents and staff."</p> <p>During an interview on 5/5/16 at 2:28 p.m., CNA #5 indicated Resident D was in the hallway and another resident touched her walker. CNA #5 indicated Resident D did not like having her possessions touched and struck out at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>other resident. CNA #5 intervened and Resident D then attempted to hit CNA #5 but she was able to avoid being hit. CNA #5 also indicated the following: "(Name of LPN #14) told a resident he was going to call the police on her and pretended to call 911. He told her should would be eating cold green bologna sandwiches in jail." CNA #5 indicated LPN #14 was intimidating Resident D and felt it was verbal abuse. CNA #5 indicated she reported this incident to the third shift nurse.</p> <p>During an interview on 5/6/16 at 2:09 p.m., LPN #13 indicated she received information on the allegation from the third shift nurse when she reported for the day shift on 4/20/16. The third shift nurse had not reported the allegation to the Administrator or the Director of Nursing. LPN #13 stated she reported the allegation to the Assistant Director of Nursing (ADON) because the Administrator and the DON were at a conference and not present in the facility.</p> <p>During an interview on 5/6/16 at 11:04 a.m., the Administrator indicated she was made aware of the allegation on 4/20/16. The Administrator indicated she instructed the ADON to suspend LPN #14 pending investigation and sent in the reportable to the State based on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>information she was provided. The Administrator indicated she was told LPN #14 had allegedly verbally abused Resident D. The Administrator was aware there were two witnesses and requested the ADON to obtain statements from both of them.</p> <p>Review of a current policy dated 7/1/11, titled "Abuse Prohibition" was provided by the Administrator on 5/5/16, this current policy indicated the following:</p> <p>"Guideline: It is the intent of this facility to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of their property (collectively, sometimes referred to as "events"). Residents will not be subjected to such events by anyone including, but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the resident, family members or legal guardians friends or other individuals. This facility shall comply with all federal and state requirements to screen, train, prevent, identify, investigate, protect and report, if applicable, any event that is not consistent with the usual operation of nursing facility or the standard care for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>certain resident.</p> <p>1. Definitions of key terms:</p> <p>a) Abuse: willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident , or visitor-to-resident.</p> <p>b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability....</p> <p>4. All facility staff, volunteers, and consultants shall be inserviced upon first employment, and at least annually thereafter, regarding Resident's Rights, including freedom from abuse, neglect, mistreatment, misappropriation of property, and the related reporting requirements....</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/06/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
---	--

(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
	<p>6. Any instances of employee disregard for the policies and procedures of this facility is cause for corrective action up to and including suspension, termination and reporting to licensing agencies....</p> <p>10. Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician families, and/or representative as required by state guidelines...."</p> <p>Review of a current policy, dated 7/1/11, titled "Abuse Reporting" was provided by the Administrator on 5/5/16. This current policy indicated the following:</p> <p>"Guideline: It is the intent of the facility to encourage and support all residents, staff, and family members feel free to report any suspected acts of abuse, neglect, involuntary seclusion, or misappropriation of resident property. The facility will take all measures possible to assure that residents, staff and families are free from reprisal, when reports or incidents are reported to the facility.</p> <p>Procedure: 1. Any person(s) witnessing or having knowledge of potential or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/06/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF MUNCIE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303		
(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	
	<p>actual abuse must contact and report the incident to the Administrator immediately. In the event the Administrator is unavailable, such report is to be made to the Administrator's Designee or the Charge Nurse who is responsible to follow through with reporting procedures...."</p> <p>This federal tag relates to Complaint IN00198687.</p> <p>3.1-28(a)</p>				