STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN 47601

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00214356. Complaint IN00214356 - Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F314, F353, and F360. Survey dates: November 14 and 15, 2016 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census bed type: SNF/NF: 35 SNF: 9 Residential: 35 Total: 79 Census payor type: Medicare: 6 Medicaid: 28 Other: 45 Total: 79 Sample: 8 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 11/16/2016 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 12/6/2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2-3.1. Quality review completed on November 21, 2016 by #02748.			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on interview and record review, the facility failed to ensure a call light was answered timely, and failed to assist the resident to the toilet and to bed when she requested, for 1 of 4 residents	F 0241	F 241 Resident G was an anonymous interview. **Completion Date 12/6/2016** All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus promotes care for the residents in a manner and in an environment that maintains or enhances each	12/06/2016

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	reviewed regarding dignity, in a sample of 8. Resident G Findings include: On 11/14/16 at 10:10 A.M., during an interview with Resident G, she indicated she frequently had to wait on her call light to be answered. Resident G indicated she was dependent on transferring to the bathroom and going to bed. She indicated staff will turn off the call light, and tell her they will be back when they can, and it then takes a long time a staff member to return. Resident G indicated she had to wait 1/2 hour for the call light to be answered; the CNA told her he was busy feeding residents and would return; and he returned 1 hour later. Resident G indicated the staff member informed her, "I'm the only one working. You have to be patient." The clinical record of Resident G was reviewed on 11/15/16 at 2:45 P.M. Diagnoses included, but were not limited to, congestive heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 10/26/16, indicated Resident G scored a 15 out of 15 for cognition, with 15 indicating no memory impairment. Resident G required extensive assistance of two+ staff for bed		resident's dignity and respect in full recognition of his or her individuality. **Completion Date 12/6/2016** All employees have been in serviced on answering call lights and leaving the light on if the employee if unable to meet the resident's need. Systemic change is the campus will complete random timed call light tests every week. **Completion Date 12/6/2016** DHS/designee will question 2 random residents concerning timeliness of answering call lights 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 12/6/2016**	

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	mobility, transfer, and toileting. A Care Plan, dated 7/15/16 and revised 10/12/16, indicated: "Problem: I am continent of B&B [bowels and bladder], but require assist [with] toileting..." Approaches included: "Ensure my call light is in reach [and] answer promptly." An additional Care Plan, dated 7/15/16 and revised 10/12/16, indicated, "Problem: I have problems providing my own care r/t [related to] s/p [status post] amputation L [left] leg." The Approaches included: "I require assist of 1 with transfers." This Federal tag relates to Complaint IN00214356. 3.1-3(t)			

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F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer on a resident's heels, and discovered one of the pressure ulcers when it had already developed eschar (dark patches of dead skin on a wound surface), and failed to ensure a dressing to a pressure ulcer was changed daily as ordered, for 2 of 3 residents reviewed with pressure ulcers, in a sample of 8. Residents A and C	F 0314	Resident A prevention plan has been reviewed and updated as appropriate. LPN #2 has been counseled related to not competing treatment as ordered on resident C. **Completion Date 12/6/2016** All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent the development of new pressure sores and provide care for current pressure ulcers in accordance	12/06/2016

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	Findings include: 1. On 11/14/16 at 9:20 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident A had a left heel wound, which was being treated by therapy 5 days a week. The clinical record of Resident A was reviewed on 11/14/16 at 11:15 A.M. Diagnoses included, but were not limited to, Multiple Sclerosis and dementia. An annual Minimum Data Set (MDS) assessment, dated 6/20/16, indicated the resident scored 11 out of 15 for cognition, with 15 indicating no memory impairment. Resident A required total dependence of two+ staff for transfer, and extensive assistance of two+ staff for bed mobility, dressing, and personal hygiene. The resident had no pressure ulcers. Documentation indicated the resident returned to the facility on 8/19/16, following hospitalization for a fractured left leg. A Physician's order, dated 8/19/16, indicated, "Remove wrap [left] leg - assess skin bid [twice a day]." Resident Progress Notes included the following notations:		with physician's orders. A skin sweep has been completed on all residents to assure accurate documentation of all wounds and proper pressure relieving interventions in place as ordered. **Completion Date 12/6/2016** All nursing staff have been in serviced concerning Proper positioning, wound prevention techniques, and identification of residents at risk to develop a pressure ulcer. All nurses have been in serviced on completion of treatment orders as written. Systemic change is any resident with a splint or brace will have the device removed every shift for skin inspection unless otherwise ordered by physician. **Completion Date 12//2016** DHS/designee will complete a random audit on 3 different residents to assure pressure relief is provided per the care plan and treatments completed as per ordered 5x a week x one month 3x a week x one month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 12/6/2016**	

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8/19/16 at 6:17 P.M.: "Resident returned from acute care stay...left leg is now in a 1/2 cast only to posterior portion of leg, the leg is covered with cotton wrap and secured with ace bandage. This area will need to be removed and assessed twice daily to monitor for skin breakdown."

8/19/16 at 6:20 P.M.: "Admission assessment complete...Resident is to keep left leg in immobilizer and the wrap is to be removed twice daily and area beneath it assessed, resident foot and toes are warm to touch she has some edema [swelling] noted...."

A Care Plan, dated 8/19/16, indicated: "Problem: I have a fractured L [left] tib/fib [leg] related to degenerative bone disease...Approach: Splint as ordered/position as needed."

Progress Notes continued:

8/20/16 at 2:48 P.M.: "LT [left] leg splint removed...to inspect pts [sic] skin integrity...no pressure areas noted lt heel, Achilles region or post aspect of leg."

A Physical Therapy Plan of Care, dated 8/23/16, indicated, "Reason for Referral:...new splint in place. Nursing made a referral to PT [Physical Therapy]

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	to address positioning, appropriate fit of splint and also to address skin integrity issues...Underlying impairments: Pt has history of MS [Multiple Sclerosis], osteopenia and osteoporosis and demonstrates decreased ROM [range of motion], strength and sensation. Pt is dependent with transfers, using total mechanical lift for transfers. Due to new splint, patient is at risk for skin breakdown due to decreased ROM, strength and coordination and patient is unable to reposition self appropriately. Also, due to MS, patient has impaired sensation which limits her ability to self moniter [sic] her skin and pain levels. Staff repositioning and skin assessments necessary to maintain skin integrity...." A Physician's order, dated 8/26/16, indicated, "Remove wrap on left leg and assess skin once a day every other day." Progress Notes continued: 8/29/16 at 2:50 A.M.: "Cont to have 2 staff for position changes and lt leg supported well along with staff working to keep good alignment of legs...Continues with protective/preventative skin care...." 9/3/16 at 3:29 P.M.: "Noted [with] splint removal from lt leg dried eschar area			

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	measuring 1.0 x 4.0 [with] loose edges area skin prepped and optifoam drsg [dressing] to lt heel area splint reapplied and heel floated on specialty air mattress...." (This was the first documented assessment of the wound sine admission 8/19/16.) A Care Plan, dated 9/3/16, indicated: "Problem: I have a pressure ulcer as evidenced by skin breakdown on my L heel...Approach: Assist me with repositioning. Continue to educate me about my pressure ulcer causes, the risk factors of developing a pressure ulcer...Please assess my skin for changes...." Progress Notes continued: 9/9/16 at 3:34 P.M.: "Dressing removed from left leg cradle splint, area unstageable pressure area on ball of heel noted...discussed interventions to relieve pressure caused by the cradle to this area...see new order regarding use of foam to cradle the heel off of the cradle splint...." 9/12/16 at 11:26 P.M.: "Unstageable area to Lt heel continues....Q [every] 4 hour skin checks...." 9/16/16 at 12:11 P.M.: "Unstageable area			

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	to left heel measures 3.4 cm x 2.4 cm black eschar intact...Therapy has applied extra padding to splint to left leg for added pressure reduction...." 9/18/16 at 11:05 P.M.: "Noted friction blister at resident right inner heel. Cause by friction from splint. Skin is intact, fluid filled blister...Applied skin prep to area and placed pillow in between legs/heel." A PT Progress Note, dated 10/17/16, indicated, "Pt presents with unstageable pressure ulcer to left heel which occurred during use of original splint following fracture...Caregivers educated regarding recommended use of splint for transfers only and to remove once pt. safely positioned in bed/chair with heels floated... The most recent skin measurements, dated 11/10/16 at 1:43 P.M., indicated, "Right heel, Stage 2 wound measures 0.6 x 0.1 x <0.1...Left heel unstageable measures 1.1 x 1.2 x U [unstageable]...." On 11/15/16 at 9:05 A.M., Resident A was observed sitting in therapy. Physical Therapist (PT) # 1 was observed doing the resident's treatment. An open ulcer was observed on her left heel. The wound had hard, yellow tissue. PT # 1 indicated			

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	the ulcer had been "unstageable," but that she could probably stage it as a "3." PT # 1 indicated the resident acquired the pressure ulcer from her left leg splint. She indicated the resident had fractured her left leg, and a splint was applied. PT # 1 indicated she thought the staff was inspecting the area, but that "after a week or so, it broke down." Resident A complained that her left heel "was sore." The resident's heel had a dressing on her right inner heel. PT # 1 removed the dressing, and a hardened, light tannish scab was observed on that. PT # 1 indicated, "Nursing takes care of that one." 2. On 11/14/16 at 9:20 A.M., during the initial tour, the DON indicated Resident C had a pressure ulcer on her heel. The DON indicated therapy was treating the area. The clinical record of Resident C was reviewed on 11/14/16 at 3:00 P.M. Diagnoses included, but were not limited to, dementia. An admission Minimum Data Set (MDS) assessment, dated 9/12/16, indicated Resident C scored a 7 out of 15 for cognition, required total assistance of two+ staff for transfer, and extensive assistance of two+ staff for bed mobility			

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	and personal hygiene. A Care Plan, dated 10/17/16, indicated, "Problem: I have a pressure injury as evidence [sic] by my skin breakdown - deep tissue injury L medial heel." The Approaches included: "Treat my wounds as ordered and evaluate the effectiveness of the treatment." A Physician's order, dated 11/8/16, indicated, "Cleanse left heel pressure injury with anasept, apply Santyl to wound bed, skin prep to peri wound cover with foam and secure with secondary dressing change q [every] day." A Nurses Note, dated 11/10/16 at 1:53 P.M., indicated, "Nursing to complete resident treatments and noted a skin impairment on lateral left heel DTI [deep tissue injury]. Area is 1.0 x .9 x .9 undetermined depth. Left heel stage 3 pressure injury measures 0.5 x 0.3 x U [undetermined]...." On 11/15/16 at 9:05 A.M., PT # 1 indicated that "Nursing takes care of [Resident C's] wound." On 11/15/16 at 9:10 A.M., LPN # 2 indicated she was caring for Resident C that day. She indicated she did not do			

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	wound care for Resident C, but "therapy does." On 11/15/16 at 9:15 A.M., a wound assessment was requested. The DON indicated that she usually changed the dressings daily, but on weekends, the nurse working would change them. She indicated she and therapy "worked together," and that she would notify therapy "as a back up" if the resident required debridement. Resident C was sitting in her wheelchair. A pillow was under both of her heels, not relieving pressure off of the heels. A dressing, dated 11/13/16, was observed on the resident's left heel. When the DON removed the dressing, a small amount of old, blackish drainage was observed. An open area was observed on the resident's left heel, with yellow tissue observed. On 11/15/16 at 2:00 P.M., the DON indicated she counseled LPN # 2 regarding not completing the resident's treatment on 11/14/16, but signing off on the Treatment Record that she had completed it. On 11/15/16 at 3:10 P.M., the Administrator provided the current facility policy, "Guidelines for Pressure Prevention," dated 8/2/16. The policy included: "Purpose To maintain good			

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	skin integrity and avoid development of pressure ulcers. Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include but not limited to:...Inspect the skin daily during care for signs of breakdown or changes to the skin...Utilize padding for casts and splints. Monitor skin closely when these devices are present...." STAGES OF PRESSURE ULCERS, AMDA - 2008, included: Stage 1: Intact skin with nonblanchable redness of a localized area, usually over a bony prominence... Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling. Note: The depth of a Stage 3 or 4 varies by anatomical location... Unstageable: Full thickness tissue loss in which the base of			

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	the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the ulcer bed. Note: Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined. This Federal tag relates to Complaint IN00214356. 3.1-40(a)(1) 3.1-40(a)(2)			

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F 0353 SS=E Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to ensure staffing was sufficient to answer call lights timely, to provide showers, to provide range of motion exercises, to administer medications and provide treatments timely, and to sufficiently pass meal trays and feed residents, for 2 of 4 residents interviewed in a sample of 8, and 7 residents attending Resident Council	F 0353	F 353 Resident's G and H were annymous interviews. **Completion Date 12/6/2016** All residents have the potential to be affected by the deficient practice and through alterations and in services the campus will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, as determined by resident assessments and individual plans	12/06/2016

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	155682	A. BUILDING 00 B. WING	11/15/2016

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	meetings. This had the potential of affecting the 49 residents living on the 100, 200, and 300 units of the facility. Residents G and H Findings include: 1. On 11/14/16 at 9:55 A.M., the Administrator provided a list of residents, highlighting those who were considered interviewable. Resident G was highlighted as interviewable. On 11/14/16 at 10:10 A.M., during an interview with Resident G, she indicated she frequently had to wait on her call light to be answered. Resident G indicated she was dependent on transferring to the bathroom and going to bed. She indicated staff will turn off the call light, and tell her they will be back when they can, and it then takes a long time a staff member to return. Resident G indicated she had to wait 1/2 hour for the call light to be answered; the CNA told her he was busy feeding residents and would return; and he returned 1 hour later. Resident G indicated the staff member informed her, "I'm the only one working. You have to be patient." 2. On 11/14/16 at 9:55 A.M., the Administrator provided a list of residents, highlighting those who were considered		of care. **Completion Date 12/6/2016** An in service/ roundtable was held to discuss staffing, meeting resident needs, answering call lights, shower schedules, range of motion services, med pass, treatments, and dining services. Systemic change is in the morning standup meeting leadership will review staffing for the upcoming day and showers from the day prior to assure completion. The DHS will review all posted nursing schedules to assure proper staffing for acuity. **Completion Date 12/6/2016** ED/designee will meet with 3 resident to assure needs being met and 3 staff member to assure sufficient staffing 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 12/6/2016**	

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	interviewable. Resident H was highlighted as interviewable On 11/14/16 at 1:35 P.M., during an interview with Resident H, she indicated that she had to wait at times for her call light to be answered. She did not give a specific time period which was worse than others, or how long she had to wait. She indicated, " I know they try their best, and I hate to complain." 3. On 11/14/16 at 10:30 A.M., the Administrator provided Resident Council minutes for the previous 3 months. The Resident Council minutes included: September 28, 2016 with 7 residents present: "Food is being served cold. Residents told its [sic] a serving problem." October 31, 2016 with 6 residents present: "Call lights take too long to be answered." November 10, 2016 with 5 residents present: "Call lights taking too long." On 11/14/16 at 10:30 A.M., the Administrator provided the nursing schedule as worked for the previous 2 weeks. The schedule indicated the facility's 100, 200, and 300 units			

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	averaged the following staff: Day shift: 3 nurses and 4-5 CNAs; Evening shift: 3 nurses and 4 CNAs; Night shift: 2 nurses and 2 CNAs. On 11/14/16 at 12:00 P.M., the Director of Nursing (DON) provided CNA assignment sheets. The assignment sheets indicated the following: 100 Unit: 24 residents; 20 residents required 1 or 2 assist with transfers, with 6 residents requiring a hoyer lift (mechanical lift); 19 residents were either on a toileting schedule or were to be checked and changed every 2 hours; and 5 residents required range of motion exercises. 7 residents had alarms for fall prevention. 200 Unit: 20 residents; 19 residents required 1 or 2 assist with transfers, with 5 residents requiring a hoyer lift; 16 residents were either on a toileting schedule or were to be checked and changed every 2 hours; and 7 residents required range of motion exercises. 5 residents had alarms for fall prevention. 300 Unit: 5 residents; 5 residents required 1 or 2 assist with transfers; 5 residents were to be checked and changed every 2 hours; 2 residents had alarms on.			

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	The assignment sheets did not indicate which residents needed to be fed or assistance with their meals. On 11/15/16 at 2:00 P.M., during an interview with the DON, she indicated staffing was based on census, and not on resident acuity. The following staff interviews were conducted on 11/14/16 and 11/15/16: Staff # 1: "It can get pretty hectic. We have a lot of residents who are total care, and require lifts. We can usually get to everyone if we have enough staff. Lately there have been only 4 CNAs." Staff # 2: "Sometimes there are 8 call lights on all at once. Everyone is wanting to go to the bathroom. We get to them all eventually." Staff # 3: "There are not enough staff to turn and toilet the residents. It's alarming seeing all of the in-house pressure ulcers and weight loss. I don't think there is enough staff to feed the residents timely, and give them a warm meal." Staff # 4: "We don't always have all of the supplies to get the treatments done. I'm not sure who orders the supplies."			

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	Staff # 5: "It's very hard to get all of the care done. Showers can't get done. It's difficult to get all of the residents up and down, and toileted. It is difficult to get all of the treatments done and pass medications timely. Sometimes we don't have the necessary supplies to do the treatments. When the census is down, there is not a staff member on the 300 hall, so we have to cover that hall too." Staff # 6: "Honestly, no, we can't get everything done. We can't get the showers done all of the time. We have a lot of residents who require lifts right now. I try to give them range of motion when I'm getting them dressed." This Federal tag relates to Complaint IN00214356. 3.1-17(a)			

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F 0360 SS=D Bldg. 00	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident received the prescribed diet, for 1 of 3 residents reviewed regarding the correct diet, in a sample of 8. Resident C Findings include: On 11/14/16 at 12:10 P.M., Resident C was observed being fed by LPN # 1. LPN # 1 indicated Resident C was on a mechanical soft diet, with nectar thick liquids. A "tray card" by the resident's plate indicated Resident C was on a mechanical soft diet with nectar thick liquids. On 11/14/16 at 3:00 P.M., the clinical record of Resident C was reviewed.	F 0360	Resident C's diet order has been clarified. **Completion Date 12/6/2016** All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will assure each resident recieves a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Each residnet'd diet has been reviewing in the campus to assure diet order is accurate. **Completion Date 12/6/2016** An in-service has been completed with all nurses on writing diet orders. Systemic change is the ST will communicate any diet changes with nursing and dietary	12/06/2016

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	A Physician's order, dated 10/14/16 and on the November 2016 orders, indicated, "Diet: Mech [mechanical] Soft, may upgrade to thin liquids." A Care Plan, dated 9/11/16, indicated, "...I am receiving a mechanically altered diet with regular liquids (10/15/16)...Approach: Provide my diet/supplements/medications as ordered." A Speech Therapist Discharge Summary, dated 10/27/16, indicated, "Pt [patient] to discharge from skilled services at this time on regular diet with thin liquids. Pt may request mechanical soft solids as needed and as a preference." A Registered Dietician note, dated 11/2/16 at 10:59 A.M., indicated, "Late entry for 10/28/16...Mechanical soft diet, thin liquids [with] fortified foods to promote weight maintenance...." On 11/15/16 at 10:50 A.M., the Dietary Manager (DM) was interviewed. The DM indicated she had just been promoted to DM the previous day. The DM indicated if there was a diet change, nursing staff would communicate it to the dietary staff and a new tray card would be made. The DM indicated she was unsure why		to assure clear communication. **Completion Date 12/6/2016** DFS/designee will complete 3 random residents diet order audits to assure accurate 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 12/6/2016**	

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	Resident C was receiving a mechanical soft diet with nectar thickened liquids, but would investigate. On 11/15/16 at 1:30 P.M., the DM provided a copy of new tray cards for Resident C. The new cards indicated Resident C would be in a Regular diet with thin liquids. The DM indicated she assumed there was a lack of communication between therapy's recommendations for a diet change, nursing staff, and dietary staff. This Federal tag relates to Complaint IN00214356. 3.1-20(a)			

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