STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHANY VILLAGE	3518 S SHELBY ST INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 7, 8, 9, 10, and 11, 2022 Facility number: 000142 Provider number: 155237 AIM number: 100266940 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 2 Medicaid: 71 Other: 14 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 17, 2022.	F 0000	F000 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after September 13, 2022.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to implement a care plan for a high risk fall, cognitively impaired resident, for 1 of 6 residents reviewed for falls. (Resident 39) Finding includes:	F 0656	**F656-Develop/Implement Comprehensive Care Plan** - **What corrective actions will be accomplished for those residents found to have been affected by the deficient**	09/13/2022

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	On 8/8/22 at 9:43 a.m., observed Resident 39 in his room. The resident was resting in his bed. A body pillow was observed on the residents bed. On 8/9/22 at 2:15 p.m., observed Resident 39 in his room, the resident was attempting to get out of bed without assistance. No staff were observed to be around at that time. The bed was without a body pillow. The resident's legs were hanging on the side of the bed and his feet were touching the floor. CNA 4 was observed to enter the room and assist the resident back to the bed. During an interview at that time, CNA 4 indicated the body pillow was removed from the resident's bed so that they could assist with his meal. The body pillow should have been put back on the bed. During an interview on 8/11/22 at 9:34 a.m., CNA 6 indicated staff knew how to take care of each individual resident by using the task sheets. The task sheets were kept at the nurse's station in a book. During an interview on 8/9/22 at 2:20 p.m., DON indicated the body pillow should have been put on the resident's bed before staff left the room after lunch. On 8/9/22 at 1:33 p.m., Resident 39's clinical record was reviewed. The diagnosis included, but was not limited to, repeated falls. The Quarterly MDS (Minimum Data Set) assessment, dated 6/15/22, indicated Resident 39's cognitive status was moderately impaired. The assessment indicated Resident 39 had two or more falls since admission. A care plan, with a start date of 3/10/22 and		**practice?** ·Staff are implementing the interventions on the fall care plan specifically the body pillow for Resident 39 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·DNS/designee to review all residents in house to ensure interventions are in place as indicated by the fall care plan by September 13, 2022 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·DNs/designee will conduct an in-service for licensed nursing staff by September 13, 2022 on following residents plan of care for falls ·Observational rounds will be completed daily by care companions/designee to ensure fall interventions are in place per plan of care **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	current through 9/15/22, indicated the resident was at risk for falls. The interventions included, but were not limited to, body pillow to the open side of the bed to enhance bed boundaries. A task sheet for the 500 hall, undated, indicated Resident 39 was "HIGH risk fall" and was to have a body pillow to the open side of the bed to enhance bed boundaries. On 8/10/22 at 8:47 a.m., the Administrator provided a policy titled, Fall Management Program, dated November 2017, and indicated it was the current policy being used by the facility. A review of the policy indicated: "Procedure Fall: Facilities must implement ...fall prevention plans for each resident at risk for falls or with a history of falls." 3.1-35(g)(2)		**assurance program will be put into place?** ·DNS/designee will be responsible for the completion of the Modified Fall Care Plan QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. By what date the systemic changes will be completed: Completion Date: September 13, 2022	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pre and post dialysis assessments were completed for 1 of 1 residents reviewed for dialysis. (Resident 50) Finding includes: On 8/9/22 at 1:46 p.m., Resident 50's clinical record	F 0698	**F698 Dialysis** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 50's pre and post	09/13/2022

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	was reviewed. The Annual MDS (Minimum Data Set) assessment, dated 6/17/22, indicated Resident 50 was cognitively intact. Resident 50's diagnoses included, but were not limited to, end stage renal disease, acute kidney failure, and dependence on renal dialysis. Resident 50 received dialysis treatment three days a week (Monday, Wednesday, and Friday). The Physician's Orders included, general hemodialysis three times a week (Monday, Wednesday, and Friday) and to send a sack lunch with resident. On 8/10/22 at 1:15 p.m., Resident 50's Dialysis Appointment Assessments were reviewed; the following assessments were missing: - On 6/17/22 (Friday) the clinical record lacked a Dialysis Appointment Assessment. - On 6/20/22 (Monday) the clinical record lacked a Dialysis Appointment Assessment. - On 7/6/22 (Wednesday) the clinical record lacked a Dialysis Appointment Assessment. - On 7/8/22 (Friday) the clinical record lacked a Dialysis Appointment Assessment. - On 8/3/22 (Wednesday) the clinical record lacked a Dialysis Appointment Assessment. - On 8/5/22 (Friday) the clinical record lacked a Dialysis Appointment Assessment. During an interview on 8/11/22 at 10:23 a.m., LPN 5 (Licensed Practical Nurse) indicated that Resident 50 should have a Dialysis Appointment Assessment completed each day he goes to dialysis. During an interview on 8/11/22 at 10:44 a.m., the Director of Nursing (DON) indicated that some of the Dialysis Appointment Assessments were		dialysis assessments are being completed with each visit **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents receiving hemodialysis services has the potential to be affected by the alleged deficient practice. ·DNS/designee will in-service licensed nurses on the Dialysis Care Policy for completing pre and post dialysis assessments with each visit by September 13, 2022 ·A chart audit of all residents currently receiving dialysis was completed by the DNS/designee by September 13, 2022 to ensure pre and post dialysis assessments are being completed per schedule **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·DNS/ designee will in-service licensed nurses on the Dialysis Care Policy for completing pre and post dialysis assessments with each visit by XXX ·DNS/designee to review dialysis assessments to ensure pre and post dialysis assessments are completed and provide education to nurses as needed	

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	missing from Resident 50's clinical record and that there should be one Dialysis Appointment Assessment completed each day he goes to dialysis. On 8/10/22 at 9:30 a.m., the DON provided a policy titled: Dialysis Care, dated November 2017, and indicated that it was the policy currently is use. The policy indicated that, "The facility will assure ...ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments ..." and "An assessment of the resident will be completed upon return from each dialysis visit ... 3.1-37(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The DNS/designee will be responsible for the completion of the Dialysis QA Tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:** ·Completion Date: September 13, 2022	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.			

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	§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to provide 8 continuous hours of Registered Nursing services seven days a week for 6 of 30 days reviewed. Findings include: On 8/9/22 at 9:40 a.m., the Administrator provided a copy of the Report of Nursing Staff Directly Responsible for Resident Care document for the previous 30 calendar days, 7/10/22 through 8/8/22. A review of the report indicated the following data for each calendar day: facility census; shift hours: day (7:00 a.m. to 3:00 p.m.), evening (3:00 p.m. to 11:00 p.m.), and night (11:00 p.m. to 7:00 a.m.); number of Registered Nurses (RN) who worked that shift; and the number of hours worked. A review of the report indicated the following: 1. On 7/10/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 84. 2. On 7/15/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 87. 3. On 7/29/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 86. 4. On 8/3/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 87.	F 0727	**F 727 RN 8 Hrs/7 days/Wk, Full Time DON** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·No residents were identified as being affected by this alleged deficient practice ·The interim ED and DNS have reviewed the schedule and have ensured at least of 8 hours of RN coverage is scheduled. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents who reside in the facility have the potential of being affected by the alleged deficient practice ·The DNS was in-serviced on RN coverage requirements. ·The ED and DNS reviewed the upcoming monthly schedule x1 and ensured RN coverage for all future days **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	09/13/2022

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	5. On 8/6/22, during the night shift, one RN had worked 1 of the required 8 continuous hours (11:00 p.m. to 12:00 a.m.) for that day. The facility census was 88. 6. On 8/7/22, the report indicated one RN had worked 7 of the required 8 continuous hours (12:00 a.m. to 7:00 a.m.) for that day. The facility census was 88. During an interview on 8/7/22 at 10:15 a.m., the Administrator indicated the facility census was 87. During an interview on 8/10/22 at 11:48 a.m., the Administrator indicated the facility lacked the required 8 hours of continuous RN coverage for 6 of 30 days between 7/10/22 and 8/8/22. The facility lacked a specific facility policy regarding the required 8 hours of continuous RN coverage. 3.1-17(b)(3)		·The DNS was in-serviced on RN coverage requirements. ·The DNS/designee will review the schedule daily to ensure at least 8 hours of RN coverage daily. If 8 hour of RN coverage is not available, actions will be taken to ensure RN coverage is present for 8 hours per day ·Each week on Monday the ED and DNS will meet and review the upcoming week schedule to ensure RN coverage for each day. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The DNS/designee will be responsible for the completion of the RN staffing QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By What date will the systematic changes be completed** September 13, 2022	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 4 of 4 kitchen observations. Dietary staff's hair was not restrained, food was not covered or dated, and perishable foods were not discarded. (Cook 1, Dietary Aide 2, Dietary Aide 3, Findings include: 1. On 8/7/22 from 9:20 a.m. to 9:35 a.m., during the initial kitchen tour with Cook 1, the following was observed: -Cook 1 was walking near the steamtable. The	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·All food currently in storage in facility has been appropriately covered, labeled, and dated. ·Cook 1 is utilizing hair net and beard restraint to cover all head and facial hair when in the kitchen ·Dietary Aide 2 is utilizing hair	09/13/2022

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	steamtable held the breakfast hot foods until they were prepared, plated, and transported to the residents. Cook 1 was also observed walking through out the kitchen area; including walking into the walk-in refrigerator and freezer units and retrieved foods from the reach-in refrigerator. Cook 1 was observed wearing baseball cap and face mask. Cook 1's hair, below the baseball cap, was 3/4 inch in length and was observed to not be covered. Cook 1's facial hair, located between the ears and the face mask, was observed to be to be 1/2 inch in length and observed to not be covered. -Dietary Aide 2 was walking near the steamtable. The steamtable held the breakfast hot foods until they were prepared, plated, and transported to the residents. Dietary Aide 2 was observed putting the left over breakfast foods into the refrigerator units. Dietary Aide 2 was observed wearing a face mask. Dietary Aide 2's facial hair, located between the ears and face mask, was observed to be 1/2 inch in length and observed to not be covered. - The kitchen's walk-in refrigerator, located near the meal prep table was observed. Inside the refrigerator unit, a tray of 10 uncooked eggs were observed. One eggshell was observed to be cracked and the egg contents, yolk and egg whites, were visible. The egg material had a dried-out appearance. During an interview at that time, Cook 1 indicated he was unaware how long the cracked egg was in the refrigerator and the egg should have been thrown out. - In the kitchen's reach-in refrigerator, located near the steamtable, two small cups of pureed Cole slaw were observed. The cups lacked a cover and a label to identify what the items were and the dates they were placed into the refrigerator. One		net and beard restraint to cover all head and facial hair when in the kitchen ·Dietary Aide 3 is utilizing hair net and beard restraint to cover all head and facial hair when in the kitchen ·BOM is utilizing hair net with all loose hairs covered when in the kitchen ·No resident have been affected by this practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·ED/Designee toured kitchen and food storage areas. Food was checked for appropriate labels and dates. Any food not properly labeled and dated were discarded. ·All staff will be in-serviced by September 13, 2022 on utilizing appropriate hair covers while in the kitchen ·Culinary staff will be in-serviced by September 13, 2022on Food Storage Policy to ensure foods are covered, labeled, and dated **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All staff will be in-serviced by September 13, 2022on utilizing	

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	covered pan, approximately 4 inches wide by 12 inches long and 3 inches deep in size was observed. The pan was filled with a white colored substance. The pan lacked a label to identify what the item was and when it was placed into the refrigerator. 2. On 8/7/22 from 11:40 a.m. to 12:20 p.m., during a follow-up kitchen observation, the following was observed: -Cook 1 was at the steamtable which held the noon meal hot foods. Cook 1 was observed taking the noon meal's hot food temperatures, plating the foods, and then preparing foods for transport to the residents. Cook 1 was observed wearing baseball cap and face mask. Cook 1's hair, below the baseball cap, was 3/4 inch in length and was observed to not be covered. Cook 1's facial hair, located between the ears and the face mask, was observed to be 1/2 inch in length, and was observed to not be covered. -Dietary Aide 2 was at the food prep table, located near the steamtable which held the noon meal's hot foods, and was preparing the resident's juice glasses. Dietary Aide 2 then placed the resident food trays, from the steamtable, into the transport cart for delivery to the residents. Dietary Aide 2 was observed wearing a face mask. Dietary Aide 2's facial hair, located between the ears and face mask, was observed to be 1/2 inch in length and observed to not be covered. -The BOM (Business Office Manager) was observed at the food prep table, located near the steamtable, that held the noon meal's hot foods, and was making peanut butter and jelly sandwiches and turkey with cheese sandwiches for the noon meal. The BOM was observed		appropriate hair covers while in the kitchen ·Culinary staff will be in-serviced by September 13, 2022on Food Storage Policy to ensure foods are covered, labeled, and dated ·The Dietary Manager/designee will complete the "Dietary Manager Daily AM Check List" daily and inspect the refrigerator to ensure the cleaning schedule is being followed and food that is being stored is properly covered, labeled, dated and hair is properly restrained **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Culinary Manager/designee will be responsible for the completion of the Short Sanitation QA tool weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By What date will the systematic changes be completed**	

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BETHANY VILLAGE	3518 S SHELBY ST INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	wearing a hair net. The BOM was observed to have multiple loose hairs, approximately 4 inches in length, hanging outside of the hair net that was located 1 inch above the ears and 3 inches above the neck hair line. The loose hairs were observed to not be covered. 3. On 8/7/22 from 1:25 p.m. to 1:30 p.m., during a follow-up kitchen observation, the following was observed: -Cook 1 was walking near the steamtable where the noon meal had been prepared, plated, and transported to the residents. Cook 1 was also observed walking through out the kitchen area where the supper meal was being prepared. Cook 1 was observed wearing baseball cap and face mask. Cook 1's hair, below the baseball cap, was 3/4 inch in length and was observed to not be covered. Cook 1's facial hair, located between the ears and the face mask, was observed to be 1/2 inch in length and was observed to not be covered. -Dietary Aide 2 was walking through out kitchen and was preparing the resident food transport cart for food delivery to the residents. Dietary Aide 2 was observed wearing a face mask. Dietary Aide 2's facial hair, located between the ears and face mask, was observed to be 1/2 inch in length and was observed to not be covered. 4. On 8/10/22 from 1:25 p.m. to 1:35 p.m., during a follow-up kitchen observation, the following was observed: -Dietary Aide 3 was observed near the steamtable where the noon meal had been prepared, plated, and ready to be transported to the residents. Dietary Aide 3 was also observed walking		September 13, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	08/11/2022

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	through out the kitchen area where the evening meal was being prepared. Dietary Aide 3 was observed wearing a hair net and a face mask. Dietary Aide 3's hair, below the hair net, was observed to be 2 1/2 inches in length and was observed to not be covered. Dietary Aide 3's facial hair, located between the ears and the face mask, was observed to be 1/2 inch in length, and was observed to not be covered. During an interview on 8/7/22 at 1:35 p.m., Cook 1 indicated all staff, while in the kitchen, were to have their hair covered. During an interview on 8/10/22 at 1:40 p.m., Dietary Aide 3 indicated kitchen staff were to have their hair covered. On 8/10/22 at 4:00 p.m., the Administrator provided a copy of the Culinary Personal Hygiene policy, dated June 2021, and indicated it was the current policy in use by the facility. A review of the document indicated, " ...wear a clean hat and/or hair restraint...employees with facial hair should also wear a beard restraint..." On 8/10/22 at 4:00 p.m., the Administrator provided a copy of the Food Storage policy, dated June 2021, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...perishable foods...to retain nutritive value and quality...foods should be covered or wrapped tightly...labeled, dated..." On 8/10/22 at 4:05 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints...hair coverings or nets, beard restraints..."			

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	On 8/10/22 at 4:15 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated "...eggs...potentially hazardous food...held in a retail food establishment...discarded...potential hazardous food...means a food that is natural...in raw shell eggs, the growth of Salmonella enteritidis [an infection commonly caused by contaminated food or water]...refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...food shall be protected from contamination by storing the food as follows:...(5). In packages, covered containers, or wrappings...wrap food tightly to prevent cross contamination..." 3.1-21(i)(2) 3.1-21(i)(3)			