

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00211393 and IN00212333.</p> <p>Complaint IN00211393 - Substantiated. Federal/State deficiencies related to the allegations are cited at F431.</p> <p>Complaint IN00212333 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, and F309.</p> <p>Survey dates: October 10, 11, & 12, 2016</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Census bed type: SNF/NF: 152 Total: 152</p> <p>Census payor type: Medicare: 18 Medicaid: 120 Other:14 Total: 152</p> <p>Sample: 8 Supplemental sample: 3</p>	F 0000	<p>This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</p> <p>The facility respectfully request paper compliance Thank you for your consideration,</p> <p>Respectfully, Jason Eastlund, BSW, HFA</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=G Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 10/14/16.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form</p>			
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	<p>of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based record review and interview, the facility failed to notify a resident's Physician in a timely manner, related to a family concern about blood sugar monitoring, for which a resident had hyperglycemia (high blood sugar) and was admitted into the hospital with a diagnosis which included, but was not limited to, diabetic hyperosmolar non-ketotic state (extremely high blood sugar level) for 1 of 3 residents reviewed for Physician notification in a total sample of 8. (Resident #G)</p> <p>Finding includes:</p> <p>Resident #G's record was reviewed on 10/12/16 at 8:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and stroke.</p>	F 0157	<p>Immediate</p> <p>Resident G was sent to the hospital for eval and treat on 8.30.16</p> <p>All others:</p> <p>Nursing management reviewed all residents and identified anyone with a dx of diabetes and or anyone who received accu checks to ensure appropriate monitoring measures were in place. Nursing management reviewed active patient records for the previous 15 days to ensure appropriate physician notification was completed. Dates 10.14.16 - 10.28.16</p> <p>Education/Systemic:</p> <p>Education was provided to all licensed nurses related to Physician Notification policy. All new</p>	11/09/2016

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	<p>A Nurses' Progress Note, dated 08/24/16 at 10:45 a.m., indicated, "paged (Physician Name) in regard for the resident history of DM (diabetes mellitus). await call back".</p> <p>The Nurses' Progress Notes, dated 08/24/16 after 10:45 a.m. through 08/29/16, indicated the Physician had not returned the call to the facility in regard to the resident's diagnosis of diabetes mellitus and the facility had not attempted to notify the resident's Physician again.</p> <p>A Nurses' Progress Note, dated 08/30/16 at 9:55 a.m., indicated the nurse was called into the room by the resident's family due to the resident being lethargic. The resident's blood sugar was obtained by the glucometer, the result was "HI", the Physician was notified and an order for insulin was received.</p> <p>A Nurses' Progress Note, dated 08/30/16 at 12:42 p.m. indicated the resident's blood sugar remained high and the resident was transferred to the hospital.</p> <p>A Hospital Emergency Room Physician History and Physical, indicated the resident's blood sugar was 1165 (normal 80-120) and the resident was admitted</p>		<p>admission or readmissions will have diagnosis and orders reviewed by a clinical manager to ensure that appropriate measures are being taken for each diagnosis.</p> <p>Monitoring</p> <p>Facility will review all new admission or readmission orders and make clarifications with physician when appropriate for 6 months. Nursing department will monitor all nursing notes, specifically looking for MD notification, for 6 months 4 X per week. Any negative findings will be reviewed in monthly QUAPI meetings.</p>	

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	<p>into the Hospital with a diagnosis which included, but was not limited to, diabetic hyperosmolar non-ketotic state.</p> <p>During an interview on 10/12/16 at 1:35 p.m., LPN #1 indicated the resident's family frequently visited the facility and the had come to the Nurses' Station to ask if the facility was doing glucometer checks (blood sugar monitoring). LPN #1 notified the Physician with the family concern that glucometer checks were not being completed or ordered. LPN #1 stated if there was no note indicating the Physician had called back, then the Physician had not called back and she had not called the Physician again.</p> <p>During an interview on 10/12/16 at 1:40 p.m., the Director of Nursing (DON) indicated if the Physician does not call back, staff should try again and if no answer, then call the Medical Director. The DON was not sure what the policy was at the facility.</p> <p>During an interview on 10/12/16 at 2:45 p.m., the DON indicated the facility did not have a policy and procedure if the Physician does not call back.</p> <p>A facility policy, titled, "Notification of Change in Resident Health Status", dated 09/30/16, and received from the DON as</p>			

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F 0282 SS=D Bldg. 00	<p>current, indicated, "...To ensure that proper notifications are made when a resident has a change in health status...A need to alter treatment significantly...Depending on the nursing assessment appropriate notification may be immediate to 48 hours..."</p> <p>This Federal Tag relates to Complaints IN00212333.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician's Orders, related to a digoxin (heart medication) dosage, for 1 of 3 residents reviewed for medications and Physician's Orders in a total sample 8. (Resident #J)</p> <p>Finding includes:</p> <p>Resident #J's record was reviewed on 10/12/16 at 11:25 a.m. The resident's diagnoses included, but were not limited</p>	F 0282	<p>Immediate</p> <p>Resident J immediately had physician and family notification completed along with order clarification. Vitals were taken on resident and no adverse consequences noted.</p> <p>All others</p> <p>Nursing management completed 100% audit on all patients that receive Digoxin to ensure</p>	11/09/2016	

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F 0309 SS=G Bldg. 00	<p>to, heart failure and diabetes mellitus.</p> <p>The Admission Physician's Orders, dated 09/26/16, indicated digoxin 0.25 mg (milligram) every morning.</p> <p>A Nurses' Progress Note, dated 09/26/16 at 11:19 p.m., indicated the resident arrived at the facility and the Physician was notified.</p> <p>The Order Summary Report, dated 10/01/16, indicated, digoxin 125 mcg (micrograms), one tablet daily.</p> <p>The Medication Administration Records, dated 09/2016 and 10/2016, indicated the resident received digoxin 125 mcg, one tablet daily.</p> <p>During an interview on 10/12/16 at 11:55 a.m., the C-Unit Manager indicated the resident had not received the correct dose of digoxin.</p> <p>This Federal Tag relates to Complaints IN00212333.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>		<p>appropriate dosage was being given per the physician order.</p> <p>Education/Systemic</p> <p>All licensed nurses were education on following physician orders. All new admission or readmissions will have diagnosis and orders reviewed by a clinical manager to ensure that appropriate measures are being taken for each diagnosis.</p> <p>Monitoring</p> <p>Nursing management will monitor 5 medication passes and 5 patient MARs per week to identify any potential medication error, for 6 months. Any negative findings will be corrected and reviewed in monthly QUAPI meeting.</p>		

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	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received the necessary treatment and services, related to not obtaining glucometer checks (blood sugar monitoring) for a resident with a diagnosis of diabetes mellitus and family concerns about the resident's blood sugar monitoring. The resident was subsequently admitted into the hospital with a high blood sugar and a diagnosis, which included, but was not limited to, diabetic hyperosmolar non-ketotic state (extremely high blood sugar level) for 1 of 3 residents reviewed for treatment for diabetes mellitus, in a total sample of 8. (Resident #G)</p> <p>Finding includes:</p> <p>Resident #G's record was reviewed on 10/12/16 at 8:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and stroke. The record indicated the resident was admitted into the facility on 08/15/16.</p> <p>A Pre-admission History and Physical,</p>	F 0309	<p>Resident G was sent to the hospital for eval and treat on 8.30.16</p> <p>All others:</p> <p>Nursing management reviewed all residents and identified anyone with a dx of diabetes and or anyone who received accu checks to ensure appropriate monitoring measures were in place. Nursing management reviewed active patient records for the previous 15 days to ensure appropriate physician notification was completed. Dates 10.14.16 - 10.28.16</p> <p>Education/Systemic:</p> <p>Education was provided to all licensed nurses related to Physician Notification policy. All new admission or readmissions will have diagnosis and orders reviewed by a clinical manager to ensure that appropriate measures are being taken for each diagnosis.</p> <p>Monitoring</p> <p>Facility will review all new admission or readmission orders and make clarifications with physician when</p>	11/09/2016

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	<p>dated 07/23/16, indicated the resident's diagnoses included, but were not limited to, diabetes mellitus and received Humalog sliding scale insulin (insulin amount given per results of the blood sugar checks).</p> <p>The Admission Physician's Orders, dated 08/15/16, indicated to obtain glucometer results every six hours. There were no insulin orders on the Admission Orders.</p> <p>The Nurses' Progress Notes, dated 08/15/16 at 4 p.m., indicated the resident was admitted into the facility.</p> <p>A Nurses' Progress Note, dated 08/15/16 at 10:15 p.m., indicated the resident was sent to the Emergency Room due to blood in the urine.</p> <p>A Nurses' Progress Note, dated 08/16/16 at 7:22 a.m., indicated the resident was admitted into the hospital.</p> <p>A Nurses' Progress Note, dated 08/17/16 at 7:13 p.m., indicated the resident returned to the facility.</p> <p>The return Admission Orders from the hospital indicated to give dextrose 40% (glucose), give 15 grams by mouth as needed. The Admission Orders lacked return orders for glucose monitoring.</p>		<p>appropriate for 6 months. Nursing department will monitor all nursing notes, specifically looking for MD notification, for 6 months 4 X per week. Any negative findings will be reviewed in monthly QUAPI meetings.</p>	

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	<p>The Nurses' Progress Notes, dated 08/17/16 at 7:11 p.m. through 08/24/16 at 10:45 a.m., indicated the Physician had not been notified for clarification of the blood sugar monitoring with the diagnosis of diabetes mellitus.</p> <p>A Nurses' Progress Note, dated 08/24/16 at 10:45 a.m., indicated, "paged (Physician Name) in regard for the resident history of DM (diabetes mellitus). await call back".</p> <p>The Nurses' Progress Notes, dated 08/24/16 after 10:45 a.m. through 08/29/16, indicated the Physician had not returned call to the facility in regard to the resident's diagnosis of diabetes mellitus and the facility had not attempted to notify the resident's Physician again.</p> <p>The resident's Nurses' Progress Notes, Medication Administration and Treatment Administration Records, dated 08/2016, indicated the resident's blood sugar had not been monitored until 08/30/16.</p> <p>A Nurses' Progress Note, dated 08/30/16 at 9:55 a.m., indicated the Nurse was called into the room by the resident's family due to the resident being lethargic.</p>			

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	<p>The resident's blood sugar was obtained by the glucometer, the result was "HI", the Physician was notified and an order for insulin was received.</p> <p>A Nurses' Progress Note, dated 08/30/16 at 12:42 p.m. indicated the resident's blood sugar remained high and the resident was transferred to the hospital.</p> <p>A Hospital Emergency Room Physician History and Physical, indicated the resident's blood sugar was 1165 (normal 80-120) and the resident was admitted into the Hospital with a diagnoses which included, but was not limited to, diabetic hyperosmolar non-ketotic state.</p> <p>During an interview on 10/12/16 at 1:15 p.m., with RN #2 and the DON (Director of Nursing), the DON indicated the resident was initially admitted to the facility at 4 p.m. and was transferred to the hospital and admitted at the same evening. The DON stated she was unsure what orders were sent with the resident and the resident did not return to the facility with orders to monitor the resident's blood sugar.</p> <p>During an interview on 10/12/16 at 1:35 p.m., LPN #1 indicated the resident's family frequently visited the facility and had came to the Nurses' Station to ask if</p>			

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F 0431 SS=D	<p>the facility was doing glucometer checks (blood sugar monitoring). LPN #1 notified the Physician with the family concern that glucometer checks were not being completed. LPN #1 stated if there was no note the Physician called back, then the Physician had not called back and she had not called the Physician again.</p> <p>A facility policy, titled, "Notification of Change in Resident Health Status", dated 09/30/16, and received from the DON as current, indicated, "...To ensure that proper notifications are made when a resident has a change in health...Depending on the nursing assessment appropriate notification may be immediate to 48 hours..."</p> <p>This Federal Tag relates to Complaints IN00212333.</p> <p>3.1-37(a)</p>				
	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS				

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Bldg. 00	<p>& BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents' medications were destroyed or returned to the Pharmacy when discontinued, expired, or the resident discharged. The facility failed to ensure</p>	F 0431	<p>Immediate</p> <p>Nursing management immediately cleaned units B and C storage room and placed appropriate medication under lock and Key per Drug Abuse Prevention and Control Act of 1976.</p>	11/09/2016	

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	<p>Residents' controlled medications when discontinued or a resident was discharged were stored securely until destroyed. The facility failed to ensure medications were labeled with a resident's and physician's name and stored in a clean and sanitary environment, for 2 of 3 Medication Rooms. (B-Unit and C-Unit) (Supplemental Resident's #K, #L, and #M)</p> <p>Findings include:</p> <p>1. During an observation of the C-Unit Medication room with the Director of Nursing (DON) on 10/11/16 at 12:25 a.m., the following was observed:</p> <p>There were blankets spread on the floor underneath the cabinet and a toilet plunger stored next to the supplies and medications stored in plastic containers.</p> <p>Supplies were stored in boxes on the floor.</p> <p>There were four plastic storage containers overflowing with multiple medications labeled with multiple resident's names. The DON indicated at the time of the observation, the medications were to be destroyed. The dates on the medications included, but were not limited to 09/26/16, 10/03/16 and the names of the</p>		<p>Prior to Survey facility had a contract in place with Steri Cycle signed, 9.21.16, for the destruction of old medications.</p> <p>All others</p> <p>Nurse management reviewed all medication rooms to ensure that space was clean and organized. Facility looked to identify any non compliant practices related to the medication storage policy and procedure. All negative findings were corrected.</p> <p>Education/Systemic</p> <p>Education was provided to all licenses nurses related to medication destruction policy and procedure. Facility contracted with Steri Cycle and will have all appropriate meds destroyed prior to date of compliance.</p> <p>Monitoring</p> <p>Nurse management will monitor the medication rooms 3 X per week for 6 months to ensure compliance with room order and med storage. Pharmacy will audit medication rooms when in the facility. Nursing management will review all discharged residents with in 72 hours of leaving to ensure medications are destroyed or returned to pharmacy appropriately for 6 month.</p>				

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	<p>medications, included, but were not limited to Neurontin (nerve pain medication), Robaxin (muscle relaxer), and Buspar (anti-depressant).</p> <p>Also found stored in a plastic storage container was a card of Lomotil (controlled medication for diarrhea) labeled with Resident #K's name and a partial bottle of liquid morphine sulfate 10 mg (milligrams) per 5 ml (milliliters) (controlled pain medication), labeled with Resident #M's name. Resident # K's record indicated the resident was discharged from the facility on 08/22/16 and Resident #M's record indicated the resident was discharged from the facility on 09/06/16.</p> <p>There were two boxes of Fentanyl 25 microgram patches (controlled pain patches) stored on the counter in the Medication Room with Resident #L's name. The DON indicated Resident #L had been discharged. Resident #L's record indicated the resident had been discharged on 06/28/16.</p> <p>There was a Sharps Container without a lid, which was half full and included syringes, stored on the counter.</p> <p>There was an expired bottle of Q-Tussin (cough syrup) with a date of 09/2016</p>			

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	<p>stored in the cabinet.</p> <p>There were open, unlabeled bottles of Vitamin D3, Cranberry Concentrate, and Vitamin B12 supplements stored in the cabinet.</p> <p>During an interview on 10/11/16 at 10:40 a.m., the C-Unit Manager indicated the measurement of the plastic storage containers were 9 inches high by 21 inches long.</p> <p>2. During an observation of the B-Unit Medication Room with the DON and the B-Unit Manager on 10/11/16 at 12:50 a.m., the following was observed:</p> <p>There were multiple bottles of medication with multiple resident names stored on top of the refrigerator. The B-Unit Manager indicated the medications needed to be destroyed.</p> <p>There were four plastic containers filled with multiple medications for multiple residents stored in the Medication Room. The dates on the medications included, but were not limited to, 03/20/16 and 05/20/16.</p> <p>There was an accumulation of dirt and dust on the floor of the Medication Room.</p>			

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	<p>The B-Unit Manager indicated at the time of the observation, the facility was working on finding someone to destroy all the medications.</p> <p>During an interview on 10/11/16 at 10:05 a.m., the Administrator indicated he just signed a contract for a company to come and destroy the medications.</p> <p>A Pharmacy Monthly Report, dated 05/2016, indicated, "...many medications requiring destruction..."</p> <p>During an interview on 10/12/16 at 11:50, the Consulting Pharmacist indicated she had been on leave for the past three months and prior to the leave she had notified the facility of the condition of the Medication Rooms. She indicated upon return from leave, in September the medication rooms had the same issues and she discussed it with the facility and they were working on the concern.</p> <p>A facility policy, titled, "Medication Destruction", dated 05/2012 and received as current from the DON, indicated, "...Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed...Medication destruction occurs</p>			

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	<p>only in the presence of at least two licensed healthcare professionals..."</p> <p>A facility policy, titled, "Controlled Substance Disposal", dated 05/2012 and received as current from the DON, indicated, "...All controlled substances remaining in the facility after a resident has been discharged, or the order is discontinued, are disposed of : 1) In the facility by the administrator (sic), director of nursing (sic) and/or consultant pharmacist...D. disposition is documented on the individual controlled substance accountability record..."</p> <p>A facility policy, titled, "Controlled Substance Storage", dated 05/2012 and received as current from the DON, indicated, "...Scheduled II-V (controlled) medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications...Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed..."</p> <p>A facility policy, titled, "Storage of Medications", dated 06/2015 and received from the DON as current,</p>			

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	<p>indicated, "...Medications...are stored safely, securely, and properly...Medications labeled for individual residents...Medication storage areas are kept clean, well-lit, and free of clutter... Medication storage conditions are monitored on a monthly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified...All expired medications will be removed from the active supply and destroyed in the facility..."</p> <p>This Federal Tag relates to Complaints IN00211393.</p> <p>3.1-25(i) 3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(n) 3.1-25(o) 3.1-25(r)</p>			