STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(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
W 0000 Bldg. 00	This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00232047. Complaint #IN00232047: Substantiated. Federal/state deficiency related to the allegation(s) is cited at W149. Survey Dates: October 23, 24, 25 and 26, 2017 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/7/17.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			

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

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	Based on record review and interview for 4 of 4 sampled clients (A, B, C and D) and two additional clients, (G and H), the facility failed to implement policy/procedures to prevent abuse/neglect/exploitation of clients by failing to protect clients C and D from theft of personal items, failure to prevent client to client abuse and failure to provide behavioral supports to client B to prevent the need to call the police and EMS (Emergency Medical Services). Findings include: The facility's investigations and BDDS reports (Bureau of Developmental Disabilities Services) were reviewed on 10/23/17 at 1:15 PM and on 10/25/17 at 1:24 PM and indicated the following: 1. 10/24/17 at 4:03 PM, client B walked out of day services with an electronic play board that belonged to the day program. Staff #3 took the board and walked back into the facility. When staff returned, client B was choking, kicking and pulling staff #4's hair and clothes. The other clients (A, C, D, E, F, and G) were removed from the facility's van and went into the day program's building with staff #4. Client B began pulling staff #3's hair and tried to pull her pants off. The behavior continued for an hour. 911 was	W 0149	**W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.** **Corrective action:** · Staff training in-service (Attachment A) on the prevention of and the policy for abuse, neglect and exploitation. (Attachment B) · Staff to be trained on the current behavior plan (Attachment C) in place for Client B and the strategies in place to prevent the need to call police and EMS due to behaviors. Strategies including: communication with day program staff prior to Client B leaving the facility, and communication between all staff at any shift change. · Staff to be trained on the theft (exploitation) policy (Attachment B) and the results of violating that policy HR Standards of Conduct Policy 7.1. (Attachment F) **How we will identify others:** · All staff to receive training on abuse, neglect and exploitation and the results of violating those policies including corrective action up to and including termination of employment. · Violation of ANE policy, if deemed appropriate, may result in the notification of the local law enforcement for further action. **Measures to be put in place:** · QIDP-D to monitor weekly	11/25/2017

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	called and the police and an ambulance came. Client B's aggression continued with kicking and grabbing the police and EMTs (Emergency Medical Technicians). Client B was taken to a hospital and released back to the facility. Interview with the Site Manager on 10/26/17 at 12:12 PM indicated the day services staff had not been able to take the electronic play board from client B before he got onto the facility's van to go home. The interview indicated the day services staff should have told the residential staff about the electronic item and discussed the situation so a behavior incident with client B could have been avoided. 2. Investigation 9/9-13/17, on 9/9/17, client C took his plate to sink and hit client H on his arm with the plate. There was no injury. 3. 8/2/17 4:10 PM, client B was on the van with peers and began elbowing client A and grabbing at staff. When the clients stepped off of the van client B grabbed client A's shirt and twisted it around his neck. Client B kicked client A in the back. Staff were grabbed and kicked in the stomach by client B. Staff instituted calming techniques in client B's Behavior Support Plan/BSP but he did not calm.		behavior documentation and report all issues on a monthly basis on Client B's monthly report and send notification to all team members of any issues with behaviors. · Staff will receive the Monthly In-service Training (Attachment E) which will review the ANE policy and Client B's behavior plan. **Monitoring of Corrective Action**: · QIDP-D to monitor behaviors monthly and document on the monthly report. Monthly report will be sent to all team members. · All trainings will be sent to the QIDP for review and then forwarded to the Training Coordinator to be filed in each employees training file. · QIDP-D and QIDP will be present at all staff meetings for a minimum of six consecutive months to review all behavioral issues and concerns for all individuals in the home. A plan will be put in place for any and all client to client aggression in an attempt to prevent peer abuse. · The abuse, neglect and exploitation policy will be followed whenever there is an allegation of ANE. An investigation will be initiated. Staff suspension will occur if warranted. Investigation will be thoroughly completed by the Quality Assurance department and follow-up will	

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	Staff called 911 and EMS and police responded. Police attempted to talk to client B and he was kicking at the officer. EMS administered an injection (unknown) and client B was taken via ambulance to an in-patient hospital facility for evaluation. Client A sustained two abrasions on his neck measuring 6 inches and a 1 inch scratch to his forearm. He was seen in a local ER (Emergency Room) for an x-ray of his back which was negative. An 8/9/17 follow-up BDDS report indicated client B was released on 8/8/17. The behavioral conclusion regarding client B was "sensory overload with feelings of over whelm (sic) creating the increase of agitation." Medications were changed and activities of listening to music, watching TV and playing with a stuffed dog were recommended. 4. An investigation dated 6/29-7/5/17 indicated client B was physically aggressive toward client C when the van arrived at the day service on 6/29/17 at 8:35 AM. Client B grabbed client C's neck and stomped on his feet. Staff initiated physical restraints three times for 5 minutes each. Police were called and arrived with an emergency unit. Client B was taken to the hospital, but no medication changes were made. Client C had 2 three inch scratches on his neck.		occur depending on investigation results. · Site Reviews will be conducted on a bimonthly basis by management staff. During the review (Attachment D), at least 25% of the individuals in the home will be interviewed with questions pertaining to their likes/dislikes and happiness with their home and peers. Answers will be documented on the site review form and all concerns relayed to the individuals teams. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager and Quality Assurance Department will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 11-25-17**	

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	5. 6/22/17 at 8:00 AM, the incident was investigated 6/22-28/17. While heading to van for transport, client G picked up a tin box, threw it and started kicking objects. He was verbally prompted to stop. He struck client C in the back and turned the coffee table over. A one person standing restraint for 45 seconds was done by staff. Client G dropped to the floor and yelled until calm. 6. 6/17/17 4:10 PM, client B was toileted and became aggressive to two staff grabbing them by the neck. They did a two person standing restraint for 5 minutes and escorted the client into his bedroom. He continued to grab staff's hair and be aggressive for an hour. The staff continued to use the standing restraint for 5 minute intervals. Staff called 911, client B was taken to the ER with an as needed order for Zyprexa (antipsychotic) medication. An OT/Occupational therapy evaluation was done (date unknown) and a weighted vest was recommended and obtained. 7. On 6/1/17, it was discovered client D, who was a smoker, was missing 5 packs and 4 individual cigarettes. There was an investigation but the perpetrator could not be found. Restitution was made by the agency and a count sheet for the			

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	cigarettes was implemented. 8. On 6/6/17 it was discovered a can of body spray was missing and two other items of a bath collection client C had won as a door prize at a gathering were missing. The investigation of 6/6-12/17 indicated a staff member had taken the body spray and given two other items belonging to client C to clients G and F. Restitution was made and the staff in question was terminated. 9. 6/6/17 2:00PM, Client B had behavioral issues and attacked staff. Two person manual restraints were used for 5 minutes. Staff called 911 for assistance, EMTs and police responded and client B was taken to the hospital. At the ER client B aggressed toward police and the doctor and was admitted. He was discharged on 6/9/17 with medication changes. 10. 2/26/17 7:30 AM, investigated 2/26-3/3/17, Client H was upset at breakfast. He was upset with client C. Client H took his fork and poked client C in the left arm with it. No injury. Client H was counseled and behavioral guidelines were written for tantrums. 11. Investigation 1/20-25/17. Client B attacked client D at the day services on			

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	1/20/17 at 2:00 PM. Client D had 2 three inch scratches to his left shoulder. Client B was in a large group music activity and began kicking peer and when redirected, attacked day program staff. It took 3 staff to direct him to go to his mat in his classroom to calm, on the way he scratched client D. Staff did a bear hug restraint for 10 minutes. Behavior continued for an hour so he was sent home. The client had medication changes. 12. 12/1/16 6:30 PM, investigated 12/1-8/16. While watching TV, client G pinched client D with no injury. Client G had been to the urologist that day and was attention seeking. 13. 11/20/16 1:00 PM, investigated 11/20-23/16. Client G was having a behavior walking through the house with staff redirecting. Client D was at the table drinking tea, client G threw his eyeglasses at client D, striking his left shoulder with no injury. Interview with Quality Assurance staff #1 on 10/23/17 at 2:30 PM indicated clients C and D had been the victims of theft. The interview indicated this was exploitation and was prohibited by the agency. Client C's items had been replaced and the perpetrator was			

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	terminated from employment. Client D's cigarettes were replaced by the agency but the perpetrator was not definitively identified. Interview with Quality Assurance staff #1 on 10/25/17 at 2:50 PM indicated the agency prohibited neglect and abuse of clients. The interview indicated client to client aggression was considered abuse. The agency's Policy (revision date of 6/30/17) entitled "Abuse, Neglect (and) Exploitation" was reviewed on 10/23/17 at 2:39 PM and indicated, in part: "ResCare strictly prohibits abuse/neglect/exploitation/mistreatment. All employees receive training upon hire regarding definitions/causes of different types of abuse/neglect/exploitation/mistreatment, how to identify prohibits abuse/neglect/exploitation/mistreatment, how to report prohibits abuse/neglect/exploitation/mistreatment, and what to expect from an investigation. All employees receive this training upon hire and annually thereafter." Definitions of prohibits abuse/neglect/exploitation/mistreatment used in agency staff training were reviewed on 10/25/17 at 3:50 PM and indicated the following: "A. Definition of Abuse			

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	1. Abuse, or any physical act by which intentional bodily harm. Any action that causes or has the potential to cause harm to another. This harm may be physical or emotional in nature. 2. Abuse is defined as slapping, punching, kicking, pinching, or any physical act by which intentional bodily harm or trauma occurs. Abuse also refers to any use of verbal, written or gestured language (in) which intimidation or fear occurs. This includes derogatory terms to describe persons with disabilities... B. Definition of Neglect 1. Neglect is the failure to act in the best interest of the individual. 2. Neglect is failure to provide Active Treatment. Hygiene care. Protective oversight. Medical care and or emotional support to those we serve...." This federal tag relates to complaint #IN00232047. 9-3-2(a)			
W 0157	483.420(d)(4)			

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Bldg. 00	STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 4 of 4 of sampled clients (A, B, C and D), the facility failed to implement corrective measures which were effective at dealing with client B's aggressive behaviors. Findings include: The facility's investigations and BDDS reports (Bureau of Developmental Disabilities Services) were reviewed on 10/23/17 at 1:15 PM and on 10/25/17 at 1:24 PM and indicated the following: 1. 10/24/17 at 4:03 PM, client B walked out of day services with an electronic play board that belonged to the day program. Staff #3 took the board and walked back into the facility. When staff returned, client B was choking, kicking and pulling staff #4's hair and clothes. The other clients (A, C, D, E, F, and G) were removed from the facility's van and went into the day program's building with staff #4. Client B began pulling staff #3's hair and tried to pull her pants off. The behavior continued for an hour. 911 was called and the police and ambulance came. Client B's aggression continued with kicking and grabbing the police and EMTs (Emergency Medical Technicians).	W 0157	**W157: Staff Treatment of Clients: If the alleged violation is verified, appropriate corrective action must be taken.** **Corrective action:** · Staff will be trained on current behavior plan (Attachment C)in place for Client B. · Alternate placement for Client B is in process. At this time, the ICAP has been completed for Client B and team is awaiting results to be sent to BDDS for determination of waiver eligibility. · Client B has already visited a home just blocks from his father's residence and both current and potential provider as well as his family believe this home to be a better fit for Client B and his diagnosis. **How we will identify others:** · QIDP-D to monitor weekly behavior documentation and report all issues on a monthly basis on Client B's monthly report and send notification to all team members of any issues with behaviors. · Client B's team members to meet on a monthly basis to ensure all needs: behavior, health and safety, are being met until alternate placement is acquired. **Measures to be put in place:** · Monthly IDT with all team members to be held for Client B	11/25/2017

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	Client B was taken to a hospital and released back to the facility. Interview with the Site Manager on 10/26/17 at 12:12 PM indicated the day services staff had not been able to take the electronic play board from client B before he got onto the facility's van to go home. The interview indicated the day services staff should have told the residential staff about the electronic item and discussed the situation so a behavior incident with client B could have been avoided. 2. 8/2/17 4:10 PM, client B was on the van with peers and began elbowing client A and grabbing at staff. When the clients stepped off of the van client B grabbed client A's shirt and twisted it around his neck. Client B kicked client A in the back. Staff were grabbed and kicked in the stomach by client B. Staff instituted calming techniques in the client B's Behavior Support Plan/BSP, but he did not calm. Staff called 911 and EMS and police responded. Police attempted to talk to client B and he was kicking at the officer. EMS administered an injection (unknown) and client B was taken via ambulance to an in-patient hospital facility for evaluation. Client A sustained two abrasions on his neck measuring 6 inches and a 1 inch scratch to his		until alternate placement is achieved. · Staff meeting to be held monthly to discuss all behavior issues and any changes needed to the behavior plan. · After every peer to peer aggression, an investigation will be completed to determine if any changes will need to be made to an individual's plans and need for additional staff training. **Monitoring of Corrective Action**: · QIDP-D will follow up with BDDS on a weekly basis to see the status of Client B's approval for waiver services. · QIDP-D and QIDP will review behavior data and determine the need for any changes to Client B's behavior plan and complete additional staff training. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager and Quality Assurance Department will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 11-25-17**	

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	forearm. He was seen in a local ER (Emergency Room) for an x-ray of his back which was negative. An 8/9/17 follow-up BDDS report indicated client B was released on 8/8/17. The behavioral conclusion regarding client B was "sensory overload with feelings of overwhelm (sic) creating the increase of agitation." Medications were changed and activities of listening to music, watching TV and playing with a stuffed dog were recommended. 3. An investigation dated 6/29-7/5/17 indicated client B was physically aggressive toward client C when the van arrived at the day service on 6/29/17 at 8:35 AM. Client B grabbed client C's neck and stomped on his feet. Staff initiated physical restraints three times for 5 minutes each. Police were called and arrived with an emergency unit. Client B was taken to the hospital, but no medication changes were made. Client C had 2 three inch scratches on his neck. 4. 6/17/17 4:10 PM, client B was toileted and became aggressive to two staff grabbing them by the neck. They did a two person standing restraint for 5 minutes and escorted the client into his bedroom. He continued to grab staff's hair and be aggressive for an hour. The staff continued to use the standing			

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	restraint for 5 minute intervals. Staff called 911, client B was taken to the ER with an as needed order for Zyprexa (antipsychotic) medication. An OT/Occupational therapy evaluation was done (date unknown) and a weighted vest was recommended and obtained. 5. 6/6/17 2:00PM, Client B had behavioral issues and attacked staff. Two person manual restraints were used for 5 minutes. Staff called 911 for assistance, EMTs and police responded and client B was taken to the hospital. At the ER, client B aggressed toward police and the doctor and was admitted. He was discharged on 6/9/17 with medication changes. 6. Investigation 1/20-25/17. Client B attacked client D at the day services on 1/20/17 at 2:00 PM. Client D had 2 three inch scratches to his left shoulder. Client B was in a large group music activity and began kicking peer when redirected attacked day program staff. It took 3 staff to direct him to go to his mat in his classroom to calm, on the way he scratched client D. Staff did bear hug restraint for 10 minutes. Behavior continued for an hour so he was sent home. The client had medication changes.			

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	Interview with Quality Assurance staff #1 on 10/25/17 at 2:50 PM indicated the agency prohibited neglect and abuse of clients. The interview indicated client to client aggression was considered abuse. Interview with Site Manager #1 on 10/26/17 at 12:12 PM indicated client B's aggressive behaviors were difficult to manage and corrective measures implemented had not proven effective. The interview indicated the police had needed to be called on occasions. The interview indicated client B was in need of a different placement. Site Manager #1 stated this placement was "too big, too loud, (and) too noisy" for client B. 9-3-2(a)			
W 0407 Bldg. 00	483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. Based on observation, record review and interview for 1 of 4 of sampled clients (B), the facility failed to obtain suitable placement for client B according to his	W 0407	**W407: The facility must not house clients of grossly different ages, development levels, and social needs in close physical or social**	11/25/2017

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	15G194	A. BUILDING 00 B. WING	10/26/2017

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RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

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	identified behavioral needs. Findings include: Client B was observed to be living in the facility during observations on 10/23/17 from 3:46 PM until 6:40 PM and on 10/24/17 from 6:00 AM until 8:12 AM. The facility's investigations and BDDS reports (Bureau of Developmental Disabilities Services) were reviewed on 10/23/17 at 1:15 PM and on 10/25/17 at 1:24 PM and indicated the following: 1. 10/24/17 at 4:03 PM, client B walked out of day services with an electronic play board that belonged to the day program. Staff #3 took the board and walked back into the facility. When staff returned, client B was choking, kicking and pulling staff #4's hair and clothes. The other clients (A, C, D, E, F, and G) were removed from the facility's van and went into the day program's building with staff #4. Client B began pulling staff #3's hair and tried to pull her pants off. The behavior continues for an hour. 911 was called and the police and an ambulance came. Client B's aggression continued kicking and grabbing the police and EMTs (Emergency Medical Technicians.) Client B was taken to a hospital and released back to the facility.		**proximity unless the housing is planned to promote the growth and development of all those housed together.** **Corrective action:** · Alternate placement for Client B is in process. At this time, the ICAP has been completed for Client B and team is awaiting results to be sent to BDDS for determination of waiver eligibility. · Client B has already visited a home just blocks from his father's residence and both current and potential provider as well as his family believe this home to be a better fit for Client B and his diagnosis. · QIDP-D will follow up with BDDS on a weekly basis to determine the status of Client B's alternate placement into a waiver setting. **How we will identify others:** · Client B's team members to meet on a monthly basis to ensure all needs: behavior, health and safety, are being met until alternate placement is acquired. · Suitable placement for any future clients will be determined based upon their identified behavioral needs and ensure growth and development of all those housed together. **Measures to be put in place:** · Monthly IDT with all team members to be held for Client B until alternate placement is achieved. · Staff meeting to be held	

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	Interview with the Site Manager on 10/26/17 at 12:12 PM indicated the day services staff had not been able to take the electronic play board from client B before he got onto the facility's van to go home. The interview indicated the day services staff should have told the residential staff about the electronic item and discussed the situation so a behavior incident with client B could have been avoided. 2.. 8/2/17 4:10 PM, client B was on the van with peers and began elbowing client A and grabbing at staff. When the clients stepped off of the van, client B grabbed client A's shirt and twisted it around his neck. Client B kicked client A in the back. Staff were grabbed and kicked in the stomach by client B. Staff instituted calming techniques in the client B's Behavior Support Plan/BSP, but he did not calm. Staff called 911 and EMS and police responded. Police attempted to talk to client B and he was kicking at the officer. EMS administered an injection (unknown) and client B was taken via ambulance to an in-patient hospital facility for evaluation. Client A sustained two abrasions on his neck measuring 6 inches and a 1 inch scratch to his forearm. He was seen in a local ER (Emergency Room) for an x-ray of his		monthly to discuss all behavior issues and any changes needed to the behavior plan. · After every peer to peer aggression, an investigation will be completed to determine if any changes will need to be made to an individual's plans and need for additional staff training. **Monitoring of Corrective Action**: · QIDP-D will follow up with BDDS on a weekly basis to see the status of Client B's approval for waiver services. · QIDP-D and QIDP will review behavior data and determine the need for any changes to Client B's behavior plan and complete additional staff training. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager and Quality Assurance Department will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 11-25-17**	

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	back which was negative. An 8/9/17 follow-up BDDS report indicated client B was released on 8/8/17. The behavioral conclusion regarding client B was "sensory overload with feelings of overwhelm (sic) creating the increase of agitation." Medications were changed and activities of listening to music, watching TV and playing with a stuffed dog were recommended. 3. An investigation dated 6/29-7/5/17 indicated client B was physically aggressive toward client C when the van arrived at the day service on 6/29/17 at 8:35 AM. Client B grabbed client C's neck and stomped on his feet. Staff initiated physical restraints three times for 5 minutes each. Police were called and arrived with an emergency unit. Client B was taken to the hospital, but no medication changes were made. Client C had 2 three inch scratches on his neck. 4. 6/17/17 4:10 PM, client B was toileted and became aggressive to two staff grabbing them by the neck. They did a two person standing restraint for 5 minutes and escorted the client into his bedroom. He continued to grab staff's hair and be aggressive for an hour. The staff continued to use the standing restraint for 5 minute intervals. Staff called 911, client B was taken to the ER			

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	with an as needed order for Zyprexa (antipsychotic) medication. An OT/Occupational therapy evaluation was done (date unknown) and a weighted vest was recommended and obtained. 5. 6/6/17 2:00PM, Client B had behavioral issues and attacked staff. Two person manual restraints were used for 5 minutes. Staff called 911 for assistance EMTs and police responded and client B was taken to the hospital. At the ER, client B aggressed toward police and the doctor and was admitted. He was discharged on 6/9/17 with medication changes. 6. Investigation 1/20-25/17. Client B attacked client D at the day services on 1/20/17 at 2:00 PM. Client D had 2 three inch scratches to his left shoulder. Client B was in a large group music activity and began kicking peer when redirected attacked day program staff. It took 3 staff to direct him to go to his mat in his classroom to calm, on the way he scratched client D. Staff did bear hug restraint for 10 minutes. Behavior continued for an hour so he was sent home. The client had medication changes. Review of IDTs (Interdisciplinary Team Meetings) on 10/26/17 at 1:40 PM			

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	indicated a quarterly review dated 8/14/17 held by QIDP-d (Qualified Intellectual Disabilities Professional designee staff) regarding client B's behaviors. The IDT indicated client B's father/guardian had been contacted and felt client B would do better in a "smaller setting." The IDT indicated the guardian had contacted BDDS to request a waiver for supported living (a home with 3 to 4 clients). The guardian also wanted the client to move closer to him so they could visit more frequently. The second IDT dated 8/28/17 indicated the waiver process had been initiated. At the time of the survey, the process had not been completed. Interview with Site Manager #1 on 10/26/17 at 12:12 PM indicated client B's aggressive behaviors were difficult to manage and corrective measures implemented had not proven effective. The interview indicated the police had needed to be called on occasions. The interview indicated client B was in need of a different placement. Site Manager #1 stated this placement was "too big, too loud, (and) too noisy" for client B. The interview indicated client B had been on a visit to another location (supported living home with two other males living there). The prospective placement was 3 blocks from his father/guardian but the			

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	plans for a move were not final. 9-3-7(a)			