STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident had his face washed and shaved for 1 of 3 residents reviewed for activities of daily living (ADL) care. (Resident K) Findings include: The clinical record for Resident K was reviewed on 9/2/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia and acute osteomyelitis. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident K needed assistance with ADL care. The goal was for him to maintain his current functional status. The interventions included, but were not limited to, assisting with bathing as needed, assisting with dressing, grooming and hygiene as needed, and encouraging him to do as much for himself as possible. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident has a DX [Diagnosis] of Vascular Dementia. Resident has impaired daily decision-making skills and poor insight into care. Resident will refuse medications or allow staff to get him out of bed at times. Resident will not allow staff to turn or reposition. Per the family resident has always been very cautious of taking medications and believed that taking vitamins was the way to maintain good health. Resident will also refuse showers at times. resident is continuously putting on his call light stating that his TV is messed up despite staff turning TV back to preferred channel each time. Resident will not have any negative side effects due to medication refusals. On 9/2/25 at 10:55 a.m., Resident K was observed lying in bed. He had a heavy growth of beard on his face with dry flakey skin in his beard. On 9/3/25 at 10:01 a.m., Resident K was observed lying in his bed. He was unshaved and had dry, flakey skin in his beard and food on his face. During an interview on 9/4/25 at 11:28 a.m., Certified Nurse Aide (CNA) 16 indicated she sometimes provided care for Resident K. He required extensive assistance with ADL care. He would sometimes refuse care, but she had not known him to refuse to wash his face or shave. He would refuse to use deodorant. Residents were usually shaved on their shower days. On 9/4/25 at 3:00 p.m., Resident K was observed lying in bed. He was unshaved and had dry skin and food stuck in his beard and on the corners of his mouth. He indicated he used to get shaved. During an interview on 9/4/25 at 3:06 p.m., Registered Nurse 18 indicated Resident K's shower days were on Wednesday and Saturday on evening shift. On 9/5/25 at 11:20 a.m., Resident K was observed sitting in his wheelchair wearing a black t-shirt. He was unshaved and had dry skin in his beard. There were dried skin flakes present by the collar of his shirt, under his chin. The corners of his mouth were red. During an interview on 9/5/25 at 11:26 a.m., Licensed Practical Nurse (LPN) 14 indicated there was dried skin in Resident K's beard and probably flakes of potato chips that he liked to eat. Resident K was picky about things. He had previously lived off the grid. During an observation on 9/5/25 at 2:24 p.m., the Director of Nursing Services (DNS) obtained a warm washcloth and gently washed Resident K's face. This citation relates to Intake 1576791.3.1-38(a)(3)(A)3.1-38(a)(3)(D)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop and implement an individualized plan of care for a resident with dementia who displayed a new behavior of making physical contact with peers for 2 of 3 residents reviewed for abuse (Resident B and Resident C). Findings include: 1a. The clinical record for Resident C was reviewed on 9/2/25 at 11:37 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and insomnia. He was admitted to the facility on [DATE]. 1b. The clinical record for Resident B was reviewed on 9/3/25 at 8:55 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbances and psychotic disorder with delusions. The resident was admitted to the facility on [DATE]. Resident C had room changes on the following dates: 5/27/25, 7/1/25, 7/16/25, 7/24/25, and 7/25/25.A Social Service Progress Note, dated 7/24/25 at 12:11 p.m., indicated Resident C's daughter gave approval for him to move rooms. A Social Service Progress Note, dated 7/25/25 at 2:57 p.m., indicated Resident C was moved to room [ROOM NUMBER] due to him not being compatible with his peer. A New/Worsening/High Risk Behavior Event, dated 7/28/25 at 3:15 p.m., indicated Resident C was in the dining area. Another resident was banging a toy on the table. Resident C grabbed the other resident by the wrists to get the toy out of their hands. The residents were separated, and Resident C was able to go to his room, away from stimulation. The intervention put into place to prevent another behavior was for Resident C to have his medications evaluated. An Interdisciplinary Team (IDT) note, dated 7/29/25 at 9:46 a.m., indicated Resident C was in the dining area when another resident grabbed an item and banged the item on the table. In an effort to stop the other resident from banging, Resident C made contact with the other resident's wrist. Both residents were immediately separated and placed in their rooms in a less stimulating environment. The assessment of potential correlation to the root cause was overstimulation in the common area. Resident C was to have labs completed and to be seen by the physician and the psychiatric provider. Resident C has had multiple room moves due to incompatible roommate. The root cause of behavioral expression was Resident C has diagnoses of dementia, cognitive impairment, and insomnia. Resident C was still adjusting to community, peers and new environment. Resident C may have been experiencing overstimulation in the dining room. Resident space invaded and peer banging on table. The preventative intervention relating to above root cause was Resident C being redirected to room to decrease overstimulation. Resident C will undergo a medication review and labs. He was added to the physician and psychiatric provider list. Resident C will have increased supervision when the other resident was present. A New/ Worsening/ High Risk Behavior Event, dated 7/29/25 at 6:46 p.m., indicated Resident C was in the dining area when another resident entered Resident C's personal space. The environment was quiet and calm. The event occurred in the common area. Resident C asked the other resident to get out of his personal space. The other resident did not respond and got closer. Resident C then grabbed the other resident in an attempt to move the other resident out of his way. The two residents were separated. The physician and family of Resident C were notified. The intervention put into place to prevent another behavior was for Resident C to be evaluated by the Psychiatric Nurse Practitioner. The clinical record did not contain a care plan addressing Resident C's new behavior of grabbing another resident. A Quarterly Minimum Data Set (MDS) assessment, completed 7/31/25, indicated he was severely cognitively impaired. He had displayed physical behaviors, such as hitting, kicking, pushing, or grabbing others, one to three days during the seven day look back period. He was able to independently perform a sit to stand transfer and independently able to walk 150 feet in the corridor. A Psychiatric Provider Progress Note, dated 7/31/25 at 7:07 a.m., indicated the visit was a New Patient Visit. Nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff reported ongoing anxiety and aggression since admission, including incidents of grabbing peers. Resident C has required six room changes due to behavioral disruptions and was currently awaiting a room move into a private room. Staff report no signs of depression, sleep disturbances, appetite changes, or hallucinations. Resident C will be started on lorazepam (anti-anxiety medication) 0.5 milligrams (mg) twice daily to target anxiety and reduce agitation. The clinical record did not contain a care plan addressing Resident C receiving lorazepam. The clinical record did not contain a care plan addressing anxiety and agitation. On 7/31/25, Resident C was moved to a different room without a roommate. A Physician's Progress Note, dated 8/1/25 at 9:35 a.m., indicated the reason for the visit was for medication review, increased agitation, and anxiety. The facility requested Resident C to be seen for medicine review. Resident C had labs received 7/30/25. He was noted with increased agitation and anxiety by facility staff. He was moved to a private room and was started on lorazepam 0.5 mg twice daily, thus resolving his agitation. A care plan, last reviewed 8/4/25, indicated Resident C had cognitive loss/ dementia and was moderately to severely impaired. The goal was for him to continue to participate in daily decisions as able and to remain alert and oriented at current status. The interventions included to encourage participation in daily activities particularly regarding orientation, socialization and stimulation. Give him choices throughout the day regarding decisions. Provide him with prompts and cues as needed. Provide him with simple instructions and repeat them as needed. A Psychiatric Provider Progress Note, dated 8/7/25 at 7:04 a.m., indicated lorazepam was initiated at the last visit to target anxiety and reduce agitation. Nursing staff reported no ongoing anxiety or aggression since lorazepam initiation and no observed side effects. Staff reported no signs of depression, sleep disturbances, appetite changes, or hallucinations. On 8/13/25, Resident B was admitted to the facility and placed with Resident C as his roommate. A Nursing Progress Note, dated 8/14/25 at 1:52 a.m., indicated on 8/14/25 at 1:47 a.m., Resident C was seen pulling Resident B by his shirt to the doorway of the room. Resident B claimed that Resident C had made contact with him. The residents were immediately separated. One-on-one attention was given to each resident. Both residents were assessed and placed on increased supervision. Resident C never appeared upset or angry, just confused. Suggested intervention was a room move. A care plan, dated 8/15/25, indicated Resident C had behavioral symptoms. Resident C had diagnoses of dementia, anxiety, and insomnia. He was at risk for peer incidents due to perceived invasion of personal space and overstimulation in busy environments. Resident C was also at risk for increased confusion or sundowning (confusion in the evening) and may attempt to make contact with peers in an attempt to redirect them. The goal was for staff to prevent triggering situations that provoke or encourage him to attempt to redirect peers through physical contact. The interventions included to build coping skills and non-physical communication methods with resident when he attempts to make contact with peers, give medications as ordered, promote respectful environment and reduce any potential triggers. The clinical record did not contain a care plan addressing Resident C's incompatibility, agitation, or aggression with roommates. A reportable incident to the Indiana Department of Health, dated 8/14/25, indicated [Resident B] claimed to staff that roommate, [Resident C] made contact with him.Immediate Action Taken: Staff immediately separated residents. Staff moved [Resident C] to room [number].Follow up: 8/19/25 Based on investigation, it is unsubstantiated that contact was made by [Resident C] to [Resident B] as described by [Resident B]. Based on investigation, [Resident C] assisted [Resident B] out of the room by resident's shirt. During this assistance, neither resident showed any signs of symptoms of psychosocial distress. According to [Resident B's Representatives] resident has a hx [history] of delusions, as referenced by [Resident B's Representatives] in other settings. In interviews with [Resident B] he has had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversations that are conflicting due to his dx [diagnoses] of dementia with psychotic disturbances, UTI [Urinary Tract Infection] and psychotic disorder with delusions . The reportable incident investigation was provided by the Administrator on 9/3/25 at 9:00 a.m. It included, but was not limited to, the following documents: A statement by Licensed Practical Nurse (LPN) 10, dated 8/17/25, indicated, On the evening of 8/13/25 this writer heard commotion down the hallway of the Meridian unit, noticed resident [C] pulling another resident [B] through the doorway of their shared room, the resident being pulled was on the floor on his back with his shirt up over his head while the other resident has both hands on his shirt pulling him. I got up and yelled for the nurse on the other unit while running to the area where the resident was now on the floor on his back leaning slightly against the wall by this time the other resident had let go of the resident's shirt. The scene was this - small/moderate amount of blood under the resident who had been pulled to the doorway, foley catheter on the floor inside room hooked to bed with the bulb inflated with small amount of urine in the catheter bag. Residents bed was in the lowest position, light in room was on. Resident that was on the floor had a polo type shirt on and a disposable brief along with non-slip socks. When asked resident that was on the floor what happened he said 'I was shot in the back I think,' nurse from other unit suggested this writer contact Administrator and DNS [Director of Nursing Services] immediately. Called facility Administrator explained what happened and she said, 'I am getting clothes on, It will take me about 30 minutes to drive in.' CNA [Certified Nurse Aide] and nurse from other unit assisted patient that was on the floor to his bed his v/s [vital signs] were taken and we assessed his body for any open areas or bruising, two small purple bruises noted on bruise of nose and the sclera [the white outer layer of the eyeball] was red. Went back and talked to the resident after he was in bed and when asked what happened he stated, 'some man got me.' Administrator came in and advised we put him in another room for the night, his bed was moved, staff was sitting in doorway of his room for the shift.An interview was conducted with LPN 10 on 9/3/25 at 10:36 a.m. She indicated, on the night of 8/13/25, she had been sitting at the nurse's station when she had heard a commotion meaning a rustling noise down the hallway. She looked up and saw Resident B was on the floor being pulled out of his room by his roommate, Resident C, by his shirt. She yelled out for LPN 9 to assist her and ran down to Resident B and Resident C's room. The residents were not observed yelling or aggressive toward one another. During that time, she had observed blood on the floor and Resident B's Foley catheter was out and the bulb still inflated. Resident B's nose was bruised, and his eye was red. Resident B had pointed to his roommate and stated, he shot me in the back. Resident C did not respond when he was asked what happened. She had not observed Resident C being aggressive to other residents before. Resident B had fallen a couple hours prior due to getting himself up without assistance to use the bathroom. After she had assessed, he did not have any injuries from the fall. Resident C was moved to another room after the incident. Later, Resident B was sent out to the hospital for an evaluation, because his blood pressure was elevated. During an interview on 9/3/25 at 2:48 p.m., CNA 11 indicated she worked with Resident C previously. She had not been informed that Resident C had a history of putting his hands on other residents. During an interview on 9/3/25 at 2:50 p.m., CNA 13 indicated she worked with Resident C previously. She was not aware that he had a history of putting his hands on other residents. During an interview on 9/3/25 at 2:14 p.m., the Dementia Care Director (DCD) indicated Resident C had several room moves due to not being compatible with roommates. The rooms at the facility were small spaces and it could be challenging to find compatible roommates. Resident C displayed sundowning in the evening with increased confusion. Resident C's behaviors seemed to be a side effect of the confusion. Resident C had worked with troubled youth in his past and was prone to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to help others. The lorazepam had been started due to increased anxiety. During an interview on 9/4/25 at 10:28 a.m., the Social Services Director (SSD) indicated a care plan had not been initiated when the new behaviors of grabbing other residents were observed on 7/28/25 and 7/29/25. The IDT team had met and reviewed the behaviors. During an interview on 9/4/25 at 11:53 a.m., Nurse Practitioner (NP) 8 indicated she had seen Resident C, on 7/31/25, and had started lorazepam for his anxiety and agitation. NP 8 was aware that Resident C had several room changes since his admission and understood at the time of her, 7/31/25, visit with Resident C, that he was to get a private room as an intervention for his anxiety and agitation. Resident C's behavior toward Resident B, on 8/14/25, was not normal behavior for Resident C. On 9/4/25 at 8:28 a.m., the Administrator provided the Behavior Management Policy, revised August 2022, which indicated .It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expression.1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other residents or caregivers. Care plan interventions should be individualized and non pharmacological interventions which address both proactive and responsive interventions. 2. Care plans should be initiated when a resident is receiving a psychotropic medication used to treat either mood or behavior. The care plan should clearly identify the specific mood, thought process or behavioral expression which the prescriber has identified as the indication for use of the psychotropic medication.7. Direct care staff will be educated as to the interventions for residents reviewed by the IDT.This citation relates to Intake 2591193 and Intake 2589663.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the facility was free of odor, clean and in good repair with linens and walls for 4 of 4 residents reviewed for physical environment. (Residents' D, F, G, and H) Findings include: A. During the initial tour of the facility on 9/2/25 at 9:55 a.m., the main entry smelled strongly of urine. Upon entering the Meridian Hills Unit, the floor in the hallway was sticky, especially around rooms [ROOM NUMBERS]. The floor between the entrance door and the nurse's station had an approximate six-inch black spot. There was a wet floor sign in the dining room beside the spot. During an observation on 9/2/25 at 2:28 p.m., the floor on the Meridian Hills Unit, between the entrance door and the nurse's station, had an approximate six-inch black spot. During a Confidential Interview 20, they indicated the Meridian Unit does have a urine odor. B. Upon entering the Mapleton Unit on 9/2/25 at 9:57 a.m., a strong urine odor was noted. An observation was conducted of the Mapleton Unit on 9/2/25 at 10:59 a.m. The unit smelled strong of urine odor. Upon entering the Mapleton Unit on 9/4/25 at 2:26 p.m., a strong urine odor was noted. C. An observation was conducted of Resident G's room on 9/5/25 at 1:11 p.m. The door frame to the bathroom was observed with chips and scratches. The bed linen had a small hole in the top right corner. During a Confidential Interview 21, they indicated the Meridian Unit recently had a urine odor when you walk in the unit. The floors were dirty, linens were worn with holes, the rooms are not kept tidy with throwing of used gloves, dirty briefs and clothing on the floor. An environmental tour was conducted, on 9/8/25 at 11:00 a.m., with the Maintenance Supervisor (MS) and the Administrator. An observation was made of Resident G's room. The bathroom door frame was observed with chips and scratches on it. A used glove was lying on the floor below the bathroom sink. During that time, the resident's linen on his bed was observed. A small hole was in the linen on the top right corner. The MS reported the top of the door frame was chipped by the door closing and the bottom half was from wheelchairs hitting it. The dirty glove on the floor at that time was removed and discarded. Next, Resident D's room was observed. The chair rail along the wall had scrapes and chips and missing a piece of the chair rail by the bed. After, Resident H's room was observed. The walls were observed with two scrapes and paint missing. An interview was conducted with the Administrator and the MS on 9/8/25 at 11:15 a.m. The Administrator indicated she had been working with the housekeeping department to replace the older linen. She recently had the floors cleaned. An interview was conducted with the MS on 9/8/25 at 11:59 a.m. He indicated the repairs were completed in the resident's room on an as needed basis. The residents' families and the staff fill out work orders that were located at the nurse's station if they observe rooms that need to be repaired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Terrace	1924 Wellesley Blvd Indianapolis, IN 46219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility does not have a policy for homelike environment. This citation relates to Intake 1576791. 3.1-19(f)(5)