STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315190	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Chateau Rehabilitation	962 River Ave Lakewood, NJ 08701

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure laundry staff performed hand hygiene immediately after removing personal protective equipment (PPE) worn while handling soiled linen prior to contacting clean laundry equipment and areas. This failure had the potential for contaminated hands to transfer pathogens from soiled linen to clean linen, equipment, and environmental surfaces, placing residents at risk for the development and/or transmission of infections. The facility housed a high-risk population with a census of 187 residents.Findings include:During a tour of the laundry area with the Laundry Manager (LM) on 03/19/26 at 7:38 AM, Laundry Technician (LT) 1 was observed transporting a commercial laundry cart containing soiled washable bed pads and mechanical lift slings, filled above the rim, from the soiled laundry area to the washer.LT1 donned disposable PPE and loaded the items into a front-loading washing machine. After loading approximately two-thirds of the contents, LT1 closed the washer door and started the machine. LT1 then pushed the soiled laundry cart back into the soiled laundry area, removed gloves, gown, and mask, and exited the soiled area. Without performing hand hygiene, LT1 proceeded into the clean laundry area, retrieved a clean laundry cart, and pushed the cart toward a dryer, touching clean equipment and surfaces.During an interview on 03/19/26 at 7:44 AM, the LM stated the proper process after handling soiled laundry included, removing PPE (gloves first, followed by gown and mask) and performing hand hygiene immediately afterward. The LM acknowledged LT1 did not perform hand hygiene after removing PPE. The LM immediately redirected LT1 to wash his/her hands. LT1 initially continued handling the clean laundry cart before stopping and performing hand hygiene after repeated instruction. The LM stated failure to perform hand hygiene after handling soiled laundry created a risk of contamination from dirty to clean areas. During an interview on 03/19/26 at 8:21 AM, the Infection Preventionist (IP) stated the facility follows the Centers for Disease Control (CDC) infection control guidelines, including standard precautions and hand hygiene. The IP stated that failure to perform hand hygiene after handling soiled laundry placed all residents at risk for cross-contamination.Review of an in-service sign-in sheet titled, PPE - Donning, Doffing, Hand Hygiene and Respiratory Illness, dated 02/20/26, included LT1's name and signature.Review of a Hand Hygiene Competency Validation, dated 02/20/26 confirmed LT1 demonstrated proper hand hygiene with soap and water, and it was validated by the LM.Review of the facility's policy titled, Departmental (Environmental Services) - Laundry and Linen, reviewed and updated 10/2025, indicated, . General Guidelines. Standard Precautions. (2) Wash hands after handling soiled linen and before handling clean linen. (3) Consider all soiled linen to be potentially infectious and handle with standard precautions. 12. Wash hands before handling clean linen (i.e., when moving from washer to dryer, moving from dryer to sorting table, and through the sorting process).Review of the facility policy titled, Personal Protective Equipment, reviewed 09/2025, indicated, . staff are trained on proper PPE use, including donning, doffing, and associated infection control practices. NJAC 8:39-19.4

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents were informed of and provided written information, upon admission, regarding their right to formulate advance directives for two residents (Residents (R) 95 and R201) of five reviewed for advance directives out of a total sample of 40 residents. This deficient practice placed residents at risk for more than minimal harm by limiting their ability to make informed decisions and communicate their healthcare preferences, including life-sustaining treatment, in the event they are unable to express their wishes.Findings included:1. Review of R95's admission Record, located under the Profile tab in the electronic medical record (EMR) revealed R95 admitted to the facility on [DATE]. Review of R95's Resident Header did not reflect an Advance Directive.Review of R95's Quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of [DATE] and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated moderate cognitive impairment. A Significant Change in Status (SCIS) MDS was completed on [DATE]. R95 previously had a BIMS of 15 out of 15, which indicated intact cognition. Review of R95's Care Plan, initiated [DATE] indicated, .I have requested that CPR [cardiopulmonary resuscitation] measures are to be performed (Full Code Status), with an intervention stating, Please follow my instructions as detailed on my POLST.Review of the Misc, tab, located in the EMR, did not reveal a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) or other advance directives documentation specifying R95's healthcare wishes.There was no evidence to indicate the facility informed R95 of or provided written information regarding advance directives upon admission. 2. Review of R201's admission Record, located under the Profile tab in the EMR, revealed R201 admitted to the facility on [DATE]. Review of R201's Resident Header did not reflect an Advance Directive.Review of R201's Care Plan, initiated [DATE] indicated, I have requested that CPR measures are to be performed (Full Code Status), with an intervention stating, Please follow my instructions as detailed on my POLST.Review of the Misc, tab, located in the EMR, did not reveal a New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) or other advance directives documentation specifying R201's healthcare wishes.During an interview on [DATE] at 1:54 PM, R201 stated a preference for Full Code status and reported he/she was not provided with information or resources regarding advance directives upon admission.During an interview and record review on [DATE] at 9:56 AM, Licensed Practical Nurse Unit Manager (LPNUM) 4 stated the admission nurse is responsible for discussing resident preferences regarding life-sustaining treatment during the admission process and documenting those preferences on the POLST form. LPNUM4 stated the POLST must be signed and dated by the resident or representative and the physician to be valid. Review of R95's and R201's medical records with LPNUM4 confirmed the absence of completed POLST forms or other advance directive documentation for both residents.Review of the facility's policy titled, Advance Directive Policy and Procedure, last reviewed 09/2025, indicated: .The resident has the right, and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide residents with a written description of the facility's policy to implement advance directives. NJAC 8:39-4.1(a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNOC) notification was provided and that the responsible party was notified for one of three residents (Residents (R) 124) reviewed for beneficiary notification out of a total sample of 40 residents. This had the potential to affect all residents being discharged from services. Findings include:Review of R124's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE].Review of R124's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 06 out of 15, indicating severe cognitive impairment.Review of R124's SNF Beneficiary Notification Review (SNF ABN), form revealed the Medicare Part A skilled services start date was 01/21/26 and the last day covered was 03/06/26. Further review revealed that R124 signed her SNF ABN form on 03/04/26.During an interview on 03/20/2026 2:06 PM, the Social Services Director (SSD) revealed residents with a BIMS lower than a 13 should not sign their SNF ABN forms due to their impaired cognition. She stated the resident's daughter told her to allow the resident to sign the form, but she had no documentation for that interview.During an interview on 03/20/26 at 3:38 PM, the Director of Nursing (DON) said she expected it was inappropriate for staff to not allow the representative to sign the SNF ABN for a resident with a BIMS of six. She agreed it was inappropriate for a resident with a BIMS of six to sign. NJAC 8:39-5.1(a)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical restraints for one resident (Resident (R) 125) reviewed for physical restraints out of 40 sampled residents. This failure had the potential to affect all residents' rights at the facility. Findings include:Review of R125's admission Record, located under the Profile tab in resident's electronic medical record (EMR), revealed the resident admitted to the facility on [DATE] with diagnoses which included Huntington's disease. Review of R125's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/09/26 and located under the MDS tab in the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated the resident's cognition was moderately impaired. Further review revealed the Posey Net Bed was classified as a restraint. Review of R125's Care Plan, dated 01/22/24 and located under the Care Plan tab in the EMR revealed, I am in a posey net bed for increased safety/decrease falls risk.Review of R125's Nurse's Note, dated 02/20/26 at 11:26 PM and located in the EMR under the Notes'' tab, written by Licensed Practical Nurse (LPN) 2 revealed, .Resident caused a disturbance in the hallway by coming out of the room without pants on. Brought back into room and placed pants back on but resident attempted to ambulate out of wheelchair. Resident placed in posey net bed for safety. During an interview on 03/20/26 at 2:43 PM, LPN2 stated Posey Net Beds were considered a restraint. He/She stated staff should attempt different interventions when a resident is being disruptive or unable to be redirected. He/She stated calling R125's wife was usually helpful or offering him/her a snack. He/She also said it was not appropriate to place a resident in a posey net bed because they could not be redirected. LPN2 stated he/she did attempt other interventions prior to placing R125 in the Posey Net bed and did call a supervisor to get guidance, but he/she did not document that, and he/she couldn't remember whom he/she spoke to. LPN2 was unsure if he/she made the decision to place R125 in the Posey Net bed on 02/20/26 or if he/she was told by someone to do so. During an interview on 03/20/2026 at 3:06 PM, Licensed Practical Nurse Unit Manager (LPNUM)3 said it would not be appropriate for staff to place a combative resident in a posey bed. He/She said the posey bed was for safety to prevent falls and not disruptive behavior. LPNUUM3 agreed that it would be a restraint for staff convivence. He/She said staff should always use the least restrictive method and attempt other appropriate interventions and document that in the medical record. During an interview on 03/20/26 at 3:38 PM, the Director of Nursing (DON) said a restraint should never be used for resident behaviors, and it was for safety only and to provide care. Review of the facility's undated policy titled, Use of Restraints, reviewed and updated 11/2025. Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to ensure three of three residents (Resident (R) 10, R12, and R197) and their resident representatives (RR) reviewed for emergent hospital transfer were provided with a written bed hold policy and transfer notice out of a total sample of 40 residents. This failure had the potential to affect the resident and their RR by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for residents transferred to the hospital.Findings include:1.Review of R10's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R10 admitted to the facility on [DATE]. Review of R10's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R10 was cognitively intact. Review of R10's Progress Notes, dated 12/10/25 and located under the Progress Notes tab of the EMR, revealed R10 was transferred to the hospital due to a fall with an abrasion to the left side of the head and returned to the facility on [DATE], later in the morning. According to documentation the facility called a contact on file and left a message, to return the call to the facility. No return call was noted. Review of R10's Progress Notes, dated 12/13/25 and located under the Progress Notes tab of the EMR, revealed R10 returned to the emergency room (ER) at a Psychiatric Emergency Screening service due to increased behaviors on 12/13/25 and returned on 12/13/25, later that day. According to documentation the facility called a contact on file and left a message, to return call to the facility. The Transfer/Bed hold notice was not provided for these visits. 2.Review of R12's admission Record, located under the Profile tab in the EMR, revealed R12 admitted on [DATE]. Review of R12's annual MDS, with an ARD of 12/02/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, indicating R12 was cognitively intact. Review of R12's Progress Notes, dated 02/23/26 and located under the Progress Notes tab of the EMR, revealed that R12 was transferred to the hospital due to being unresponsive to verbal and tactile stimulation and returned to the facility on [DATE]. The Transfer/Bed hold notice was not sent to the Power of Attorney (POA) until 03/10/26 per documentation provided by the facility. According to documentation the facility called R12's power of attorney (POA) and made notification. 3.Review of R197's admission Record, located under the Profile tab in the EMR, revealed the resident admitted to the facility on [DATE]. Review of R197's quarterly MDS, with an ARD of 11/04/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated R197 was cognitively intact. Review of R197's Progress Note, dated 12/26/25 and located under the Progress Note tab of the EMR, revealed R197 had a change in condition. A new order was received to send to R197 to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital for evaluation and treatment. Review of the Notice of Emergency Transfer, form dated 12/26/25, and provided by the facility for R197, revealed that the document was sent to the Long-Term Care Ombudsman but not the resident. During an interview on 03/20/26 at 11:35 AM, the Receptionist (RCPT) stated R197 was not provided with a copy of the transfer notice, and one was not mailed to her emergency contact.During an interview on 03/20/26 at 3:38 PM, the Director of Nursing (DON) said the transfer notice should be provided to the resident or representative within 24 hours of discharge. NJAC 8:39-4.1(a)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure that a discharge Minimum Data Set (MDS) assessment was submitted timely for two residents (Resident (R) 31 and R13) reviewed for MDS assessments out of a total sample of 40 residents. The failure to submit the discharge MDS did not allow for the closure of the residents' MDS cycle.Findings include:1. Review of R31's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R31 admitted to the facility on [DATE]. Further review revealed R33 was discharged to the hospital on [DATE].Review of R31's discharge MDS, with an assessment reference date (ARD) of 11/27/25 and located under the MDS tab of the EMR, revealed the assessment was completed but not submitted.2. Review of R13's admission Record, located under the Profile tab of the EMR, revealed R13 admitted to the facility on [DATE]. Further review revealed that R13 was discharged to the hospital on [DATE].Review of R13's discharge MDS, with an assessment reference date of 11/16/25 and located under the MDS tab of the EMR, revealed the assessment was completed but not submitted.During an interview on 03/20/26 at 2:41 PM, the MDS Coordinator stated both assessments were missed due to the coding to submit to the Centers for Centers for Medicare and Medicaid Services (CMS) not being updated. He/She stated they should have been submitted after they were completed in November 2025.During an interview on 03/20/26 at 3:38 PM, the Director of Nursing (DON) said He/She expected MDS assessments to be submitted timely after they were completed.Review of the facility policy titled, Comprehensive Assessments, revised 10/2025 revealed, . Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. NJAC 8:39-11.2

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility policy, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for two residents (Resident (R)25 and R163) reviewed for MDS accuracy out of a total sample of 40 residents. This failure placed residents at risk of unmet care needs.Findings include: 1. Review of R25's admission Record, located under the Profile tab in the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type II, chronic multifocal osteomyelitis left foot/ankle, and Charcot's joint left ankle/foot.Review of R25's Nursing Skin/Wound Note, dated 01/26/26 and located under the Notes tab in the EMR revealed, admission skin assessment with [Name of Wound Care company] done this morning. Chronic left lateral malleolus diabetic foot wound with Charcot deformity and chronic osteomyelitis.Review of R25's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/02/26 and located under the MDS tab in the EMR, revealed R25 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Section I for Active Diagnosis did not include the diagnoses of osteomyelitis and Charcot's foot. Section M for skin condition did not assess the resident has having a diabetic foot.During an interview on 03/20/26 at 2:50 PM, the Minimum Data Set Coordinator (MDSC) reviewed the admission MDS for R25's diagnoses with osteomyelitis left foot and ankle and Charcot foot stated it should have been listed on the list for Active Diagnosis, and it must have been an oversight. The MDSC confirmed R25's documentation should have included the venous/arterial ulcers. 2. Review of R163's admission Record, located under the Profile tab in the EMR, revealed the resident initially admitted to the facility on [DATE] with diagnoses that included spinal stenosis of lumbar region, scoliosis, muscle wasting, and morbid obesity.Review of R162's quarterly MDS with and ARD of 06/17/25 and located under the MDS tab of the EMR, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact. Section J for Health Conditions failed to reveal that the resident sustained any falls during the assessment period.Review of R162's Fall Scale Assessment, completed on 06/17/25 and located under the Assessments tab in the EMR identified the resident was at low risk for falling. Review R162's Post Fall Assessment, completed on 06/01/25 and located under the Assessments tab in the EMR identified the resident was at moderate risk for falling.Review R162's Nurses Notes, dated 06/01/25 located under the Notes tab in the EMR indicated the resident slid from the wheelchair to a sitting position trying to get back into bed. No injuries were sustained.During an interview on 03/19/26 at 4:10 PM, Licensed Practical Nurse Unit Manager (LPNUM)1 revealed the resident sustained a fall last year without injuries. The resident has not sustained any falls since that time. During an interview on 03/20/26 at 2:50 PM, the MDSC nurse revealed the resident's quarterly MDS dated [DATE] did not reflect the fall the resident sustained on 6/7/25. The MDSC agreed that since the fall without injury occurred during the assessment period it should have been reflected on that quarterly MDS.A review of the facility policy tilted, Comprehensive Assessments, with a revision date of 10/2025 revealed, .Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.Review of the October 2024 RAI, manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. It is important to note here that information obtained should cover the same observation period as specified by the MDS (minimum data set) items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT (interdisciplinary team) completing the assessment. NJAC 8:39-33.2(d)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure residents did not have bedrails when they were not assessed to have them for one of four residents (Resident (R) 28) reviewed for side rails out of a total of 40 sampled residents. The lack of appropriate assessment could lead to potential restraint or side rail entrapment. Findings include:Review of R28's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R28 admitted to the facility on [DATE] with diagnosis of Huntington's Disease.Review of R28's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/15/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. Review of R28's Care Plan, dated 09/19/23 and located under the Care Plan tab of the EMR, revealed R28 was care planned for top half side rails on the right side of the bed. Review of R28's Physician Orders, located under the Orders tab in the EMR, dated 03/18/26, revealed no current order for side rails.Review of R28's Quarterly/Annual/Significant Change Nursing Evaluation Packet, dated 01/06/26 and located under the Assessments tab in the EMR, revealed side rails were not necessary at this time.During observations on 03/18/26, 03/19/26 and 03/20/26, a side rail was observed on the left side of R28's bed in the up position. During an interview on 03/20/26 at 10:38 AM, the Licensed Practical Nurse Unit Manager (LPNUM)3 said he/she was aware R28's siderail assessment indicated he/she was not supposed to use side rails. He/She said the residents changed units and R28 was placed in a bed that already had a side rail on it but that it should be removed. During an interview on 03/20/26 at 3:38 PM, the Director of Nursing (DON) stated a resident should not have bedrails unless they are assessed to require them. Review of the facility policy titled, Bed Safety and Bed Rails, Reviewed and Updated 11/2025 revealed, . Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. NJAC 8:39-27.1(a)