| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLANCHE DRIVE | 6208 BLANCHE DRIVE<br>RALEIGH, NC 27607 |

| (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 125 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(3)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure client #5 had the right to a legal guardian. This affected 1 of 3 audit clients. The finding is:<br><br>Review on 4/25/22 of client #5's individual program plan (IPP) dated 9/16/21 revealed client #5 has a diagnosis that includes Profound Intellectual Disability, Unspecified Disruptive Impulse Control/Conduct Disorder, Cerebral Palsy, Quadriplegia and a Seizure Disorder. Further review of client #5's IPP revealed she does not currently have a legal guardian.<br><br>Interview on 4/26/22 with the executive director confirmed client #5 does not currently have a legal guardian. | W 125 | | |
| W 247 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(vi)<br><br>The individual program plan must include opportunities for client choice and self-management.<br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure that 1 of 3 audit clients (#4) received a choice of a nutritious meal. The finding is:<br><br>During breakfast observations in the home on | W 247 | | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______<br>B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE**<br>**RALEIGH, NC 27607** |

| (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 247 | Continued From page 1<br>4/26/22 at 7:51am, client #4 drunk a cup of coffee and ate two cut pieces of toast. On her plate were sliced bananas and cooked oatmeal. Client #4 showed no interest in her food and never took a bite. After 15 minutes, client #4 got up and left the table. The home manager asked client #4 to return to the table to clear her dishes. The HM did not offer client #4 any food substitutions for breakfast.<br><br>Interview on 4/26/22 with the HM, she acknowledged client #4 was not offered something else to eat for breakfast.<br><br>Interview on 4/26/22 with the executive director revealed that he observed Staff C, Staff A and the HM not offer client #4 a breakfast alternate when she refused to eat what was served on the menu. | W 247 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#3 and #4) received a continuous active treatment program consisting of needed interventions and services as identified in the | W 249 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLANCHE DRIVE | 6208 BLANCHE DRIVE RALEIGH, NC 27607 |

| (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 249 | | W 249 | | |

Continued From page 2
Individual Program Plan (IPP) in the areas of program implementation regarding meal guidelines; and positioning guidelines, the use of adaptive devices and foot stool. The findings are:

A. During lunch observations in the home on 4/25/22 at 12:30pm, Staff A served bite size pieces of deli meat and vegan cheese sandwich, sliced clementine oranges, V-8 juice and water to client #4. Client #4 was 2 of 5 clients sitting at the table, who was independent with feeding. Client #4 sat at the end of the table and consumed her beverages and food rapidly, while Staff B stood with her back turned to client #4 and fed client #3; Staff A stood and faced client #2 who was assisted with eating and the home manager (HM) stood to feed client #5, faced away from client #4. None of the staff sat next to client #4 during the course of her meal. Client #4 did not consistently use her utensils and took a sandwich portion off of client #2's plate and ate it before staff could intervene.

During dinner observations in the home on 4/25/22 at 5:10pm, the HM assisted client #4 scoop shredded baked chicken, cooked carrots, and beans on her plate for dinner. Client #4 was given a fork and spoon. Staff A stood with her back to client #4 to feed client #2, Staff D fed client #5 and the HM stood next to client #1. Client #4 did not have any staff sitting next to her at the meal. Client #4 finished her drinks before she began eating large pieces of chicken, and overstuffed her mouth, eating at a face pace. An additional observation at the conclusion of dinner, client #4 noticed client #1's spilled food on the floor. Client #4 reached down to eat a piece of food off the floor but the HM took it away. When the HM resumed assisting to clear the table,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE RALEIGH, NC 27607** |

| (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 249 | Continued From page 3 | W 249 | | |

client #4 reached down on the floor and picked up three more pieces of food and ate them, while no one noticed.

Review on 4/25/22 of client #4's IPP dated 5/11/21 revealed client #4 was noted to eat too fast at meals and needed to have meat cut into bite size pieces. Staff needed to sit within arm's reach at all meals. Staff to encourage client #4 to put down her spoon after every bite.

Interview on 4/26/22 with the HM, who acknowledged that staff did not sit next to client #4 during her meals and that she did not observe client #4 eating the other food debris off of the floor.

B. During observations in the home at lunch and dinner on 4/25/22 and breakfast on 4/26/22, client #3 was observed sitting in a wheelchair with a chest harness. Throughout the meal time observations, client #3 was observed to lean forward and to her left side.

Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed she is supported by a wheelchair with chest harness to provide proper positioning when dining.

Review on 4/26/22 of client #3's Positioning Guidelines dated 1/21 revealed, "secure chest harness across her chest at all four points to improve sitting position."

Interview on 4/26/22 with Staff C revealed client #3 should be seated in an upright position when she is eating.

Interview on 4/26/22 with the executive director

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLANCHE DRIVE | 6208 BLANCHE DRIVE RALEIGH, NC 27607 |

| (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 249 | Continued From page 4 | W 249 | | |

confirmed client #3 should be sitting in an upright position when she is eating.

C. During observations in the home throughout the survey on 4/25/22 - 4/26/22, client #3 was observed wearing a gait vest. Throughout the observations, client #3 was observed to ambulate in her home with staff holding her arm/elbow or by holding her fingers.

Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed client #3 is supported with a gait vest that is to be used while ambulating for the purpose of ambulation, physical redirection and to prevent/minimize falls.

Interview on 4/26/22 with Staff C revealed staff should always assist client #3 with ambulating by holding the gait vest as she is a risk for falls.

Interview on 4/26/22 with the executive director confirmed that when client #3 is ambulating, staff should be holding the back of the gait vest.

D. During observations in the home throughout the survey on 4/25/22 - 4/26/22, client #3 was observed to sit in various locations in the home such as a chair on the front porch, in the living room and in the medication room . During the observations, client #3's feet did not touch the floor. A foot stool was located in the living room of the home but at no time was the foot stool provided for client #3 to put her feet on.

Review on 4/25/22 of client #3's IPP dated 2/18/22 revealed client #3 utilizes a foot stool when sitting to assist with proper positioning.

Interview on 4/26/22 with Staff C revealed client

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______<br>B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE**<br>**RALEIGH, NC 27607** |

| (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 249 | Continued From page 5<br>#3's foot stool should be used anytime she is sitting up.<br><br>Interview on 4/26/22 with the executive director confirmed client #3 should utilize a foot stool anytime she is sitting up and her feet do not touch the floor to assist with proper positioning. | W 249 | | |
| W 262 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(i)<br><br>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 3 audit clients (#3 and #5) was reviewed and monitored by the human rights committee (HRC). The findings are:<br><br>A. Review on 4/25/22 of client #3's individual program plan (IPP) dated 2/18/22 revealed an objective for client #3 to display zero episodes of physical aggression and non-compliance. Review on 4/25/22 of client #3's Behavior Support Plan (BSP) dated 6/9/21 revealed no review or consent by the HRC.<br><br>Interview on 4/26/22 with the executive director confirmed that based on the consent located in the record, client #3's BSP was not reviewed or consented to by the HRC.<br><br>B. Review on 4/25/22 of client #5's IPP dated 9/16/21 revealed an objective for client #5 to display zero episodes of non-compliance and | W 262 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE RALEIGH, NC 27607** |

| (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 262 | Continued From page 6<br>physical aggression and one or fewer episodes of inappropriate verbalizations. Review on 4/25/22 of client #5's BSP dated 6/9/21 revealed no review or consent by the HRC.<br><br>Interview on 4/26/22 with the executive director confirmed that based on the consent located in the record, client #5's BSP was not reviewed or consented to by the HRC. | W 262 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 3 audit clients (#3 and #5). The findings are:<br><br>A. Review on 4/25/22 of client #3's Individual Program Plan (IPP) dated 2/18/22 revealed client #3 is supported by co-guardians. Further review of client #3's IPP revealed an objective for client #3 to display zero episodes of physical aggression and non-compliance.<br><br>Review on 4/25/22 of client #3's Behavior Support Plan (BSP) dated 6/9/21 revealed only one guardian had authorized and consented to the BSP.<br><br>Interview on 4/26/22 with the executive director confirmed written informed consent for client #3's BSP had not been obtained by both co-guardians. | W 263 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLANCHE DRIVE | 6208 BLANCHE DRIVE RALEIGH, NC 27607 |

| (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 263 | Continued From page 7<br><br>B. Review on 4/25/22 of client #5's IPP dated 9/16/21 revealed an objective for client #5 to display zero episodes of non-compliance and physical aggression and one or fewer episodes of inappropriate verbalizations.<br><br>Review on 4/25/22 of client #5's BSP dated 6/9/21 revealed no consent by a legal guardian.<br><br>Interview on 4/26/22 with the executive director confirmed written informed consent for client #5's BSP had not been obtained. | W 263 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to furnish 1 of 3 audit clients (#3) a wheelchair in good repair. The finding is:<br><br>During observations in the home at lunch and dinner on 4/25/22 and breakfast on 4/26/22, client #3 was observed sitting in a wheelchair with a chest harness. The back of the chest harness on the left side was attached to the wheelchair with a bolt/screw, while the right side of the chest harness was unattached from the screw hole and tied in a knot around the handle of the wheelchair. Throughout the meal time observations, client #3 was observed to lean | W 436 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE RALEIGH, NC 27607** |

| (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 436 | Continued From page 8<br>forward and to her left side.<br><br>Review on 4/25/22 of client #3's Individual Program Plan (IPP) dated 2/18/22 revealed she is supported by a wheelchair with chest harness to provide proper positioning when dining.<br><br>Review on 4/26/22 of client #3's Positioning Guidelines dated 1/21 revealed, "secure chest harness across her chest at all four points to improve sitting position."<br><br>Interview on 4/26/22 with Staff C revealed she does not know how long the chest harness strap had been broken. Staff C confirmed it is difficult to position client #3 in a proper, upright position due to the strap being broken.<br><br>Interview on 4/26/22 with the home manager revealed she had noticed on 4/25/22 that the buckle of client #3's chest harness was broken, but was not sure how long the strap had been broken. | W 436 | | |
| W 440 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1)<br><br>at least quarterly for each shift of personnel.<br>This STANDARD is not met as evidenced by:<br>Based on document review and staff interview, the facility did not conduct the appropriate number of fire drills, per quarter. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6).<br><br>During record review on 4/26/22 of the facility's fire drill log, it revealed there was no documented fire drills during May, June and July 2021. | W 440 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G083 | A. BUILDING ______ B. WING ______ | 04/26/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BLANCHE DRIVE** | **6208 BLANCHE DRIVE RALEIGH, NC 27607** |

| (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 440 | Continued From page 9<br>Interview on 4/26/22 with the home manager revealed she pulled the fire drills from last year and did not retain all the copies.<br><br>Interview on 4/26/22 with the executive director (ED) stated that they needed to have a system to store the fire drills after they have been completed. | W 440 | | |
| W 441 | EVACUATION DRILLS<br>CFR(s): 483.470(i)(1)<br><br>and under varied conditions to-<br>This STANDARD is not met as evidenced by:<br>Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings is:<br><br>Review on 4/26/22 of facility's fire drill reports for July 2021-April-2022 revealed the fire drills were not conducted during varied times for all three shifts.<br><br>Interview on 4/26/22 with the home manager revealed she did not know the drills had to be done at different times. | W 441 | | |