



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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June 16, 2014

Bridger Fly, Administrator
Communicare, Inc #1 Gem
40 West Franklin Road, Suite F
Meridian, ID 83642

RECEIVED

JUN 27 2014

FACILITY STANDARDS

RE: Communicare, Inc #1 Gem, Provider #13G008

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #1 Gem, which was conducted on June 5, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Bridger Fly, Administrator
June 16, 2014
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 29, 2014**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by June 29, 2014. If a request for informal dispute resolution is received after June 29, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #1 GEM	STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651
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(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
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<p>W 000 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 6/2/14 to 6/5/14.</p> <p>The survey was conducted by: Ashley Henscheid, QIDP, Team Leader</p> <p>Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional CMP - Comprehensive Metabolic Panel HPV - Human Papillomavirus IDT - Interdisciplinary Team ILW - Instructional Lead Worker IPP - Individualized Program Plan LPN - Licensed Practical Nurse OT- Occupational Therapy QIDP - Qualified Intellectual Disability Professional RN - Registered Nurse</p> <p>W 125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in implementation of blanket</p>	<p>W 000</p> <p>W125</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">FACILITY STANDARDS</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">JUN 27 2014</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">RECEIVED</p> <p>-W-125</p>	<p><u>Exercising Rights:</u> The citation begins with following statements: "... the facility must allow and encourage individual clients to exercise their rights as clients of the facility, as citizens of the United States, including the right to file complaints, and the right to due process." "... This resulted in implementation of blanket restrictions to personal possessions, not based on individual need, and without assuring due process."</p> <p>Before specifying corrective actions there are some factors that collectively have resulted in the situation observed by surveyors that we would like to clarify.</p> <ol style="list-style-type: none"> 1) Individual #4 legally deaf and legally blind and has a well-documented history of ingestion of fluids containing alcohol and restrictive measures were in place at her last residence for her protection. 2) When Individual #4 moved to CCI #1, management staff were instructed to make sure that items she has ingested in the past were not available to her. 3) We were viewing this as a protection of harm issue rather than a rights issue for everyone else who lives at this location. 4) We agree that we did not view this action as a restriction of the rights of others related to personal possessions, acknowledge the error of our ways, and will take corrective actions. 	<p>08/05/14</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	6/25/2014

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

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W125 CONTINUED

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- a. A target behavior will be added to her Behavior Management/ Support Plan about behavioral interventions to help her respect the property of others.
- b. The QIDP will start a "Less Restrictive Intervention" log related to this issue and should restrictions become necessary, we have a well-developed consent process that will be implemented for Individual #4 and for any of her housemates whose property might need to be protected.

1) Rights Training

Although neither individuals at this location or their guardians have complained about this issue, we feel we could do a better job of training about protecting and respecting rights both with both individuals served and employees. We have found an excellent pictorial document called "Bill of Right—People First—Responsibilities" on the internet and are attaching the page involving personnel possessions as a sample of the training on rights (Attachment A) we plan to use as a training tool at this location.

Our intent is to make a copy of this material for each individual; to develop a weekly group training session using this material as a base; to supplement this material, over time, with some additional training materials (probably social stories); and to supplement existing staff training material (our "Rights" module) with this document.

2) Management Training

Although this issue had been thoroughly reviewed with the surveyor, on 06/26/14 the QIDP

Supervisor met with the QIDP and Assistant QIDP (House Manager). We discussed each of our roles in the development of this issue, why our actions were problematic, and our obligation to protect individuals from possible harm while continuing to respect both their rights and the rights of their housemates.

3) Staff Training

Instructional staff were inservices on these concerns 06/24/14 and will be inserviced further as structural changes are made and additional training materials are developed.

Identifying Others Potentially Affected:
As indicated, all individuals at this location are affected

System Changes: Please refer to corrective actions.

Monitoring:

- 1) A "Restriction Review Log" has been developed (Attachment B).
- 2) For at least the next three months or until we feel assured that this issue is resolved, the QIDP will conduct bi-monthly environmental checks which will focus on any items that are locked up and other possible restrictive practices. These observations will be documented on the "Restriction Review Log" which will be stored in the Observation Binder and problematic checks will be reviewed with management staff so that corrective action can be implemented as necessary. The QIDP will continue this practice on at least a quarterly basis thereafter.
- 3) The QIDP will be responsible for implementing the changes described related to information development and training activities. Implementation plans and efforts will be discussed with and monitored by the QIDP supervisor to ensure the intent of change is accomplished. The QIDP supervisor will document these actions on a QIDP log.

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W 125 Continued From page 1
restrictions to personal possessions, not based on individual need, and without assuring due process protections. The findings include:

1. An environmental review was conducted with the AQIDP on 6/3/14 from 11:30 a.m. - 12:15 p.m. At that time, it was noted that shower supplies as well as six containers, each with a toothbrush and toothpaste, were locked under the bathroom sink of the common bathroom. The containers were labeled with the initials of Individuals #2 - #4 and #6 - #8. Individual #2 and #5's personal bathroom was reviewed and it was noted their toothbrushes and tubes of toothpaste were also locked in containers under their bathroom sink.

When asked, the AQIDP stated the items were locked up upon Individual #4's admission because she would ingest non-food items, including toothpaste.

Additionally, a container including a hairbrush, hair accessories, a spray water bottle and hairspray, labeled with Individual #4's initials, was locked in the left, upper, laundry room cabinet. Also in that cabinet was a container of make-up and a pouch of nail polish. The AQIDP stated the nail polish belonged to Individual #8 and was locked up because Individual #4 woke up in the middle of the night, went into Individual #8's bedroom and poured the nail polish on Individual #8's clothes. The AQIDP stated the make-up belonged to Individual #7 and she did not know why it was locked up.

Individual #1 - #4's records were reviewed on 6/4/14. No documentation related to the locked items could be found.

W 125 Corrective Actions:
1) Personal Property

- The ladies living at CCI #1 are used to their grooming boxes being stored in the area below the sink and find this to be convenient.
- Individual #4 has some personal care needs which require that cleaning supplies be immediately available to staff after toileting activities to ensure the sanitation of the bathroom and these chemical supplies must be locked.
- The space where both of these types of items is currently locked and is under the bathroom sink. This space will be partitioned into two sections. The left section will be unlocked and will continue to store the ladies personal care items, none of which are toxic. The right section will be locked and will store chemical cleaning supplies.
- As soon as this partition is in place we will unlock the right side of this space.
- Staff are to be with Individual #4 when she toilets and will work with her on not disturbing other's grooming kits.
- Individual #4's grooming kit will be located in her bedroom drawer so she can become used to obtaining her own grooming kit from this area instead of from under the sink.

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W 137	<p>Continued From page 3</p> <p>When asked, the AQIDP stated the items were locked up upon Individual #4's admission because she would ingest non-food items, including toothpaste.</p> <p>Additionally, a container including a hairbrush, hair accessories, a spray water bottle and hairspray, labeled with Individual #4's initials, was locked in the left, upper, laundry room cabinet. Also in that cabinet was a container of make-up and a pouch of nail polish. The AQIDP stated the nail polish belonged to Individual #8 and was locked up because Individual #4 woke up in the middle of the night, went into Individual #8's bedroom and poured the nail polish on Individual #8's clothes. The AQIDP stated the make-up belonged to Individual #7 and she did not know why it was locked up.</p> <p>Individual #1 - #4's records were reviewed on 6/4/14. No documentation related to the locked items could be found.</p> <p>When asked, the QIDP stated during an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., she was unaware the possessions were locked. She stated no programming, consents or approvals were in place for the intervention.</p> <p>The facility failed to ensure individuals' right to retain and use personal possessions was upheld.</p> <p>The facility was previously cited at W137 during the annual recertification survey, dated 7/10/13.</p>	W 137	
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE	W 259	

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W 259 Continued From page 4

At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure assessments were updated annually or as needed for 1 of 4 individuals (Individual #2) whose assessments were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include:

1. Individual #2's IPP, dated 5/8/14, documented a 40 year old female whose diagnoses included profound mental retardation.

Her record contained an Occupational Therapy Report, dated 3/20/07. The report included the following recommendations:

- "1. [Individual #2] does not demonstrate a need for formal OT services.
2. Annual evaluations should be completed to determine consistent level of functioning.
3. Maximize aerobic type of activity to assist with constipation."

The report also included a handwritten note, dated 4/1/07 and written by the facility QIDP, which documented "Based on recommendation #1 the IDT has decided to evaluate [Individual #2] every 5 years."

However, Individual #2's record did not contain evidence of an occupational therapy assessment after 3/20/07.

W 259

Corrective Actions: This was an oversight by the QIDP. We have located an Occupational Therapist who is very skills in working with individuals with intellectual disabilities and an appointment will be scheduled.

Identifying Others Potentially Affected: We do not believe that others at this location were affected, but to make sure, the QIDP will review all records related to these types of recommendations and schedule follow-up accordingly.

System Changes: Given that there was one such finding during surveyors review, we do not feel this is a systems issue. However, counseling with this QIDP related to this issue occurred 06/26/14 as documented by this plan of correction.

Monitoring: Our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews will be specified on CCI's annual calendar.

08/05/14

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W 259 Continued From page 5

When asked, the QIDP stated during an interview on 6/5/14 from 9:40 - 12:30 p.m., an updated evaluation had not been done.

The facility failed to ensure Individual #2's record included updated information regarding her occupational therapy needs.

W 264 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE

The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

This STANDARD is not met as evidenced by:
Based on observation, record review and staff interview, it was determined the facility failed to ensure the HRC reviewed and approved facility practices that restricted individuals' free access to household items for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in access to personal possessions being restricted without cause. The findings include:

1. An environmental review was conducted with the AQIDP on 6/3/14 from 11:30 a.m. - 12:15 p.m. At that time, it was noted that shower supplies as well as six containers, each with a toothbrush and toothpaste, were locked under the bathroom sink of the common bathroom. The containers were

W 259

W 264

Corrective Action: Please refer to corrective action related to this rights issue at W125. As our thinking was that the actions taken were protective due to ingestion issues rather than a restriction of rights, we did not seek informed consents or HRC approval. We have a well-developed Informed Consent Process and will implement it based on data collected at this location related to actual ingestion risks as specified previously.

Identifying Others Potentially Affected:
All individuals at this location were affected by this issue.

Systems Changes: Please refer to W125.

Monitoring: Please refer to W125.

08/05/14

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W 264 | Continued From page 6

labeled with the initials of Individuals #2 - #4 and #6 - #8. Individual #2 and #5's personal bathroom was reviewed and it was noted their toothbrushes and tubes of toothpaste were also locked in containers under their bathroom sink.

When asked, the AQIDP stated the items were locked up upon Individual #4's admission because she would ingest non-food items, including toothpaste.

Additionally, a container including a hairbrush, hair accessories, a spray water bottle and hairspray, labeled with individual #4's initials, was locked in the left, upper, laundry room cabinet. Also in that cabinet was a container of make-up and a pouch of nail polish. The AQIDP stated the nail polish belonged to Individual #8 and was locked up because Individual #4 woke up in the middle of the night, went into Individual #8's bedroom and poured the nail polish on Individual #8's clothes. The AQIDP stated the make-up belonged to Individual #7 and she did not know why it was locked up.

Individual #1 - #4's records were reviewed on 6/4/14. No documentation related to the locked items could be found.

When asked, the QIDP stated during an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., she was unaware the possessions were locked. She stated no programming, consents or approvals were in place for the intervention.

The facility failed to ensure all practices resulting in potential rights violations were reviewed and approved by the HRC.

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W 278 Continued From page 7

W 278 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR

Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.

This STANDARD is not met as evidenced by:
Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 4 individuals (Individual #4) residing in the facility. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include:

1. Individual #4's IPP, dated 5/27/14, documented she was a 30 year old female whose diagnoses included profound mental retardation. She was admitted to the facility on 3/6/14 from a sister facility in the company.

An environmental review was conducted with the AQIDP on 6/3/14 from 11:30 a.m. - 12:15 p.m. At that time, it was noted that shower supplies as well as six containers, each with a toothbrush and toothpaste, were locked under the bathroom sink of the common bathroom. The containers were labeled with the initials of Individuals #2 - #4 and #6 - #8. Individual #2 and #5's personal bathroom was reviewed and it was noted their

W 278

W 278

Less Restrictive Interventions
Corrective Actions: Please refer to W125 for specific corrective actions

Identifying Others Potentially Affected:
All individuals at this location were affected by this issue.

Systems Changes: Please refer to W125.

Monitoring: Please refer to W125.

08/05/14

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W 278 Continued From page 8

toothbrushes and tubes of toothpaste were also locked in containers under their bathroom sink.

When asked, the AQIDP stated the items were locked up upon Individual #4's admission because she would ingest non-food items, including toothpaste.

Additionally, a container including a hairbrush, hair accessories, a spray water bottle and hairspray, labeled with Individual #4's initials, was locked in the left, upper, laundry room cabinet. Also in that cabinet was a container of make-up and a pouch of nail polish. The AQIDP stated the nail polish belonged to Individual #8 and was locked up because Individual #4 woke up in the middle of the night, went into Individual #8's bedroom and poured the nail polish on Individual #8's clothes. The AQIDP stated the make-up belonged to Individual #7 and she did not know why it was locked up.

Individual #1 - #4's records were reviewed on 6/4/14. No information related to less restrictive interventions attempted prior to locking personal possessions could be found.

When asked, the QIDP stated during an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., she was unaware the possessions were locked. The AQIDP, also present during the interview, stated the items were locked away from Individual #4 because the facility she was discharged from also locked up the identified items.

The facility failed to ensure less restrictive interventions for Individual #4's maladaptive behaviors had been systematically tried and proven to be ineffective prior to restricting access

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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #1 GEM		STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651		
(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 278	Continued From page 9 to individuals' personal possessions.	W 278		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 4 individuals (Individual #4) whose behavior plans were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include: 1. Individual #4's IPP, dated 5/27/14, documented she was a 30 year old female whose diagnoses included profound mental retardation. She was admitted to the facility on 3/6/14 from a sister facility in the company. An environmental review was conducted with the AQIDP on 6/3/14 from 11:30 a.m. - 12:15 p.m. At that time, it was noted that shower supplies as well as six containers, each with a toothbrush and toothpaste, were locked under the bathroom sink of the common bathroom. The containers were labeled with the initials of Individuals #2 - #4 and #6 - #8. Individual #2 and #5's personal bathroom was reviewed and it was noted their	W 289	<u>Appropriate Interventions</u> Corrective Actions: Please refer to W125 for specific corrective actions Identifying Others Potentially Affected: All individuals at this location were affected by this issue. Systems Changes: Please refer to W125. Monitoring: Please refer to W125.	08/05/14

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W 289: Continued From page 10.

toothbrushes and tubes of toothpaste were also locked in containers under their bathroom sink.

When asked, the AQIDP stated the items were locked up upon Individual #4's admission because she would ingest non-food items, including toothpaste.

Additionally, a container including a hairbrush, hair accessories, a spray water bottle and hairspray, labeled with Individual #4's initials, was locked in the left, upper, laundry room cabinet. Also in that cabinet was a container of make-up and a pouch of nail polish. The AQIDP stated the nail polish belonged to Individual #8 and was locked up because Individual #4 woke up in the middle of the night, went into Individual #8's bedroom and poured the nail polish on Individual #8's clothes. The AQIDP stated the make-up belonged to Individual #7 and she did not know why it was locked up.

Individual #4's behavior plan, dated 5/2014, documented she engaged in maladaptive behavior including ingesting inedible items. However, no information related to locking up items (e.g. which items to lock up, when to lock them, etc.) was present in the plan.

When asked, the QIDP stated during an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., she was unaware the possessions were locked. She stated no programming, consents or approvals were in place for the intervention.

The facility failed to ensure the restriction of personal possessions, due to Individual #4's inappropriate ingesting behavior, was sufficiently incorporated into her behavior plan.

W 289

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W 322 483.460(a)(3) PHYSICIAN SERVICES

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 2 of 4 individuals (Individuals #1 and #3) whose medical records were reviewed. This resulted in individuals not receiving follow-up appointments as recommended. The findings include:

1. Individual #1's IPP, dated 5/8/14, documented a 48 year old female whose diagnoses included severe mental retardation.
 - a. Individual #1's medical record included a letter, dated 9/21/10, which documented Individual #1's mammogram, completed 9/16/10, was normal. The letter stated "Your next mammogram should be done in one year." However, record of a more recent mammogram could not be found.
- During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated she could not locate any evidence of an updated mammogram. Additionally, the ILW and AQIDP, who were also present during the interview, could not locate documentation of a mammogram for Individual #1 in her record or on the facility appointment calendar.
- b. Individual #1's medical record was reviewed and did not include documentation of a pap smear. The record included an Office History

W 322 | General & Preventative Medical Care

08/05/14

Corrective Actions:

- 1) Individual #1 had a mammogram 06/23/14.
- 2) Individual #1 has a history of refusing to participate in gynecological visits, especially pelvic examinations and PAP smears.
 - a. We have located a general practitioner and an OBGYN practice who are both willing to work with us on this issue.
 - b. One of the OBGYNs in this practice has indicated that an HPV swab may supersede the need for a pap smear (see attached article). This option will be discussed at Individual #1's 07/01/14 appointment and, in our opinion would be a preferable option if not medically contraindicated. Our plan is to recommend that a pelvic exam and an HPV swap without sedation be attempted. If this is unsuccessful or if the medical provider does not support this approach a follow-up appointment using sedation will be scheduled so that a pelvic exam and PAP smear can be completed.
- 3) An appointment will be scheduled for Individual #3 related to the pap smear issue and the plan outlined above will be implemented.

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W 322 : Continued From page 12
and Physical note, dated 10/6/10, which documented "The patient does not tolerate exams. Exam was attempted; however, it was not able to be accomplished even with 3 other assistants."

Additionally, Individual #1's record included a letter, dated 11/12/10, which documented "Due to the history of negative pap smears/HPV tests and the absence of sexual activity, I recommend this client be seen every 3 years." However, record of a pap smear could not be found.

During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated an updated pap smear had not been completed. She stated Individual #1's last successful pap smear was in 2007.

The facility failed to ensure Individual #1 was provided with preventative screenings as recommended.

2. Individual #3's IPP, dated 5/1/14, documented a 60 year old female whose diagnoses included moderate mental retardation.

Individual #3's medical record was reviewed and evidence of a recent pap smear could not be found.

Individual #3's record included an Office Progress Note, dated 4/1/11. The note documented "Last Pap was 11/2007."

During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated she thought Individual #3 had undergone a pap smear more recently, but she could not locate any documented

W 322 : Identifying Others Potentially Affected: The LPN assigned to this location and the RN supervisor will do a Quality Assurance Check at this location and any similar issues identified will be responded to as outlined above.

System Changes: We have systems in place to deal with this type of issue and the RN Supervisor should have discovered these types of issues during the monthly nursing services review process. The RN Supervisor hired 10/13 is rapidly learning and implementing her job duties and further inservice was done by the QIDP Supervisor based on survey results 06/26/14 with both as documented on this plan of correction.

Monitoring: The RN Supervisor will be reviewing medical records for thoroughness and follow-up on a monthly basis. In addition, our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff including nurses. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews will be specified on CCI's annual calendar.

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W 322 Continued From page 13 evidence.

W 322

The facility failed to ensure Individual #3 was provided with a pap smear as recommended.

W 325 483.460(a)(3)(iii) PHYSICIAN SERVICES

W 325

The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 2 of 4 individuals (Individuals #1 and #3) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:

1. Individual #1's IPP, dated 5/8/14, documented a 48 year old female whose diagnoses included severe mental retardation.

Individual #1's record included a Physician's Order Sheet and Progress Note, dated 5/2014. The sheet included an order for lipid and hemoglobin A1C levels to be measured every 6 months.

Individual #1's medical record was reviewed and showed routine blood work had been completed on 5/31/13 and 5/21/14. However, the 5/21/14 report did not include levels for hemoglobin A1C. Additionally, neither of the laboratory reports included lipid levels. Further, six month lab levels

Annual Examinations/Laboratory
Corrective Actions:

08/05/14

- 1) Our organization was dealing with some nursing coverage issue both at the LPN and RN levels 06/13-11/13 and the LPN assigned to this location additionally has some personal health issues between 08/13-11/13.
- 2) Orders for the missing blood work will be obtained from the primary physician 07/14.
- 3) The LPN has been counselled about these expectations as documented by this plan of correction.
- 4) Both the LPN and the RN Supervisor were additionally trained by the QIDP Supervisor about these issues 06/26/14.

Identifying Others Potentially Affected:
The LPN assigned to this location and the RN supervisor will do a Quality Assurance Check at this location and any similar issues identified will be responded to as outlined above.

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W 325 Continued From page 14 for 11/2013 could not be found.

During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated the last lipid levels she could locate for Individual #1 were completed in 9/2011 and 11/2013 blood work had not been completed.

The facility failed to ensure Individual #1 received standard laboratory screenings as ordered.

2. Individual #3's IPP, dated 5/1/14, documented a 60 year old female whose diagnoses included moderate mental retardation.

Individual #3's record included a Physician's Order Sheet and Progress Note, dated 5/2014. The sheet included an order for lipid and hemoglobin A1C levels to be measured every 6 months.

Individual #3's medical record was reviewed and showed routine blood work had been completed on 2/28/13 and 3/6/14. However, six month lab levels for 8/2013 could not be found.

During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated the 8/2013 blood work had been missed.

W 325 System Changes: We have systems in place to deal with this type of issue and we had limited RN coverage and support for oversight purposes for a period of time. The RN Supervisor hired 10/13 is rapidly learning and implementing her job duties. We feel this is a training rather than a systems issue.

Monitoring: The RN Supervisor will be reviewing medical records for thoroughness and follow-up on a monthly basis. In addition, our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff including nurses. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews will be specified on CCI's annual calendar.

W 339 483.460(c)(4) NURSING SERVICES

Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.

W 339

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W 339 : Continued From page 15

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure nursing services were provided to address the needs of 2 of 4 individuals (Individuals #1 and #3) whose medical records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:

1. Individual #1's IPP, dated 5/8/14, documented a 48 year old female whose diagnoses included severe mental retardation.

a. Individual #1's record included a Physician's Order Sheet and Progress Note, dated 5/2014. The sheet included an order for CMP, lipid and hemoglobin A1C levels to be measured every 6 months.

Individual #1's record included documentation of quarterly pharmacy reviews. Pharmacist notes, dated 11/15/13, documented "Q [every] 6 mo labs -> Lft (CMP), Lipids, HgbA1C due 11/13."

However, six month lab levels for 11/2013 could not be located in Individual #1's record.

During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated Individual #1's 11/2013 blood work had not been completed.

The nurse failed to ensure Individual #1 received routine blood work as prescribed by her physician and as noted by the pharmacist.

b. Individual #1's medical record included a letter, dated 9/21/10, which documented Individual #1's mammogram, completed 9/16/10, was normal.

W 339 :

Nursing Care

Corrective Actions:

- 1) Our organization was dealing with some nursing coverage issue both at the LPN and RN levels 06/13-11/13 and the LPN assigned to this location additionally has some personal health issues between 08/13-11/13.
- 2) Orders for the missing blood work will be obtained from the primary physician 07/14.
- 3) All reports received from other physicians will now be review with the primary physician as documented by his signature and date on subsequent reports.
- 4) Both the LPN and the RN Supervisor were additionally trained by the QIDP Supervisor about these issues 06/26/14.
- 5) Please refer to W322, W325, and W356.

Identifying Others Potentially Affected:
The LPN assigned to this location and the RN supervisor will do a Quality Assurance Check at this location and any similar issues identified will be responded to as outlined above.

08/05/14

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W 339	<p>Continued From page 16</p> <p>The letter indicated "Your next mammogram should be done in one year." The letter indicated one of Individual #1's physicians received the results of the mammogram.</p> <p>However, Individual #1's record included a second letter, dated 11/12/10, which documented "Breast exams are to continue on a yearly basis while mammograms will be done every other year until the age of 50." The letter was signed by a different physician than the one involved with Individual #1's mammogram.</p> <p>When asked, during an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated she could not locate evidence that Individual #1's physician was notified of the second physician's change in recommendations.</p> <p>The nurse failed to ensure Individual #1's physician was notified of a change in Individual #1's mammogram recommendation.</p> <p>The facility failed to ensure sufficient communication and monitoring related to Individual #1's health care needs to ensure nursing services were provided as prescribed by her physician.</p> <p>2. Individual #3's IPP, dated 5/1/14, documented a 60 year old female whose diagnoses included moderate mental retardation.</p> <p>Individual #3's record included a Physician's Order Sheet and Progress Note, dated 5/2014. The sheet included an order for lipid and hemoglobin A1C levels to be measured every 6 months.</p>	W 339	<p>System Changes: We have systems in place to deal with this type of issue and we had limited RN coverage and support for oversight purposes for a period of time. The RN Supervisor hired 10/13 is rapidly learning and implementing her job duties. We feel this is a training rather than a systems issue.</p> <p>Monitoring: The RN Supervisor will be reviewing medical records for thoroughness and follow-up on a monthly basis. In addition, our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff including nurses. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews will be specified on CCI's annual calendar.</p>

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W 339	<p>Continued From page 17</p> <p>Individual #3's record included documentation of quarterly pharmacy reviews. Pharmacist notes, dated 11/15/13, documented "Obtain the q [every] 6 mo lipid panel and A1C, last 2/13." Additionally, pharmacist notes, dated 2/28/14, documented "Obtain q 6 month lipid and HgbA1C lab results for the chart at earliest convenience."</p> <p>Individual #3's medical record was reviewed and showed routine blood work had been completed on 3/6/14. However, six month lab levels for late 2013 could not be located in Individual #3's record.</p> <p>During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated the 8/2013 blood work had been missed.</p> <p>The nurse failed to ensure Individual #3 received routine blood work as prescribed by her physician and as noted by the pharmacist.</p> <p>The facility failed to ensure Individual #3 received nursing services as prescribed by her physician.</p> <p>3. Refer to W322 as it relates to the facility's failure to ensure individuals were provided with general and preventative medical care.</p> <p>4. Refer to W325 as it relates to the facility's failure to ensure individuals received standard laboratory screenings as ordered.</p> <p>5. Refer to W356 as it relates to the facility's failure to ensure an individual received recommended dental care.</p>	W 339		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT	W 356		

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W 356	<p>Continued From page 18</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive dental services were provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual's dental needs being un-addressed. The findings include:</p> <p>1. Individual #1's IPP, dated 5/8/14, documented a 48 year old female whose diagnoses included severe mental retardation.</p> <p>Individual #1's medical record included dental notes, dated 7/17/13, which documented a recommended recall of 6 months. However, record of a more recent dental examination could not be found.</p> <p>During an interview on 6/5/14 from 9:40 a.m. - 12:30 p.m., the LPN stated she had been scheduling individuals for annual visits only. She stated she thought it was a procedure the former RN put into place and thought it may have been payment related, but six month dental visits had not been completed.</p> <p>The facility failed to ensure Individual #1 received the recommended dental care.</p>	W 356	<p><u>Comprehensive Dental Treatment</u></p> <p>Corrective Action: The changes in Medicaid Reimbursement related to dental care for persons with intellectual disabilities caused us some systems problems in the area related which were not sufficiently managed by our previous RN Supervisor. Reimbursement systems are scheduled to change 07/14 and should make this a less complex issue. Additionally there was confusion on instructional staff's part related to dental hygienist recommendations which were typically routine 6 months follow-up for cleanings versus dentist's recommendations which sometimes were for annual checkups. Nurses don't typically attend dental appointments so the RN Supervisor will develop a "Dental Visit Protocol" for instructional staff giving them specific direction on clarifying these two issues as well as having the issue of routine x-rays (having these done or documenting why not) addressed which has been an organizational issue.</p> <p>Identifying Others Potentially Affected: The LPN assigned to this location and the RN supervisor will do a Quality Assurance Check at this location and any similar issues identified will be responded to as outlined above.</p>	08/05/14

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 6/2/14 to 6/5/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional IPP - Individualized Program Plan LPN - Licensed Practical Nurse	W356 → M 000 ←	System Changes: We have systems in place to deal with this type of issue and we had limited RN coverage and support for oversight purposes for a period of time. The RN Supervisor hired 10/13 is rapidly learning and implementing her job duties. We feel this is a training rather than a systems issue and additional training was provided by the QIDP Supervisor 06/26/14. Monitoring: The RN Supervisor will be reviewing medical records, including dental records, for thoroughness and follow-up on a monthly basis. In addition, our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff including nurses. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews will be specified on CCI's annual calendar.	
MM111	16.03.11.050.01(c) Medical History A medical history and a physical examination must be completed by a physician not more than ninety (90) days before admission. The medical history and the record of the physical examination must include information concerning the resident's activity limitations and the results of a tuberculin skin test or chest x-ray. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate tuberculin testing had occurred for 1 of 1 individual (Individual #4) admitted to the facility within the past year. This resulted in the potential for an infected individual to be admitted to the facility undetected. The findings include: 1. Individual #4's IPP, dated 5/27/14, documented she was a 30 year old female whose diagnoses included profound mental retardation. She was admitted to the facility on 3/6/14 from a sister facility in the company. Individual #4's record was reviewed and did not contain documentation that tuberculin testing had	MM111 MM111	We understood that PPDs were required upon admission but considered this individual's move a transfer rather than an admission. This has now been clarified for us and a PPD will be completed by 07/01/14.	08/05/14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **6/25/2014**

STATE FORM 6599 JMG011 If continuation sheet 1 of 6

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #1 GEM		STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651		
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MM111	Continued From page 1 occurred as part of her pre-admission or admission process. During an interview on 6/5/14 from 9:40 - 12:30 p.m., the LPN stated tuberculin testing was not completed for Individual #4's admission because she did not know it was required when an individual moved from a sister facility. The facility failed to ensure appropriate tuberculin testing had taken place related to Individual #4's admission.	MM111		
MM168	16.11.03.075.07(a) Rights as a Citizen Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125 and W278.	MM168	Please refer to W125 and W278.	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W264.	MM194	Please refer to W264	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and	MM197	Please refer to W289	

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MM197	Continued From page 2 This Rule is not met as evidenced by: Refer to W289.	MM197	
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	Please refer to W137
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted with the AQIDP on 6/3/14 from 11:30 a.m. - 12:15 p.m. During that time, the following was noted: - In Individual #1 and #5's restroom,	MM380	MM380 We make a concerted effort to maintain this home in an attractive and safe manner. We have a maintenance man and a system to detect and address needed repairs. The items found were either not found on our Preventative Maintenance Checklist or were pending repair. <ul style="list-style-type: none"> • Baseboard in bathroom coming off the wall will be reattached • Drawers in the common restroom will be placed back on rails and backstops will be repaired • Drawers in the kitchen will be placed back on rails and backstops will be repaired • The seam of carpet in the exercise room will be repaired The above list will be provided to Maintenance Man for repair. In

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MM380	Continued From page 3 approximately 10 inches of baseboard was separated from the wall at the base of the shower. - All three of the drawers in the common restroom were broken from the rails and without backstops, causing them to fall forward when opened. - The bottom three drawers to the left of the stove were broken from the rails and without backstops, causing them to fall forward when opened. - Three of the upper, middle drawers between the sink and fridge storage area were broken from the rails and without backstops, causing them to fall forward when opened. - The seam of carpet in the exercise room was separated in an approximately six foot strip. The facility failed to ensure environmental repairs were maintained.	MM380	addition, the AQIDP will be in-serviced in using the Preventative Maintenance Check list to notify the Maintenance Man of repair needs and the Administrator will periodically review the check list with AQ to verify the content.	
MM724	16.03.11.270.01(a) Assessments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W259.	MM724	Please refer to W259	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are	MM735	Please refer to W322	

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MM735	Continued From page 4 brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	Please refer to W325	
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W339.	MM760	Please refer to W339	
MM782	16.03.11.270.04(a)(i) Extraoral and Intraoral Examination A complete extraoral and intraoral examination must be performed, utilizing all diagnostic aids necessary to properly evaluate the resident's oral	MM782	Please refer to W356	

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MM782	Continued From page 5 condition. This Rule is not met as evidenced by: Refer to W356.	MM782		