STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. BUILDING _____ B. WING _____	02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT SQUARE	501 OAK AVENUE WAYNESBORO, VA 22980

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/09/2021 through 02/10/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/09/2021 through 02/10/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code report will follow. The census in this 18 certified bed facility was 14 at the time of the survey. The survey sample consisted of eleven (11) current resident reviews, and three (3) closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		3/5/21

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

Electronically Signed | 02/23/2021

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 14 residents in the survey sample. Resident #1 had no individualized care plan to address non-drug interventions for pain. The findings include: Resident #1 was admitted to the facility on 7/27/20 with diagnoses that included femur fracture, right hip joint replacement, idiopathic	F 656	F 656 1. Resident #1 now has an individualized care plan to address non-drug interventions for pain. 2. A chart review of other residents will be completed to assure individualized care plans are in place for residents with pain to address non-drug interventions. 3. The RN MDS/Unit Manager will be in-serviced by the Director of Nursing pertaining to completing individualized	

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F 656	Continued From page 2 neuropathy, atherosclerotic heart disease, congestive heart failure, hyperlipidemia, cerebral infarction, depression, glaucoma, chronic kidney disease and neuralgia. The minimum data set (MDS) dated 1/19/21 assessed Resident #1 as cognitively intact and as frequently experiencing pain. On 2/9/21 at 10:37 a.m., Resident #1 was interviewed about quality of life/care in the facility. Resident #1 stated he frequently had pain in his right arm/hand and left leg. Resident #1 stated pain medications were provided when requested and were usually effective. Resident #1's clinical record documented current physician orders for the following medications for pain/neuropathy. Tylenol 650 mg every 4 hours as needed for mild pain Gabapentin 200 mg every 4 hours as needed Oxycodone 5 mg every 4 hours as needed for moderate/severe pain Morphine concentrate 20/mg/milliliter - 0.25 ml every 4 hours as needed for pain Resident #1's medication administration record (MAR) for 2/1/21 through 2/9/21 documented the resident was administered Tylenol 650 mg once on 2/3/21 for headache pain. The MAR documented Gabapentin 200 mg was administered for hand pain on 2/5/21. Resident #1 was administered Oxycodone 5 mg on 2/1/21, 2/2/21, 2/3/21 (2 doses), 2/4/21 and 2/9/21 and Morphine .25 ml on 2/5/21, 2/6/21 (2 doses) and 2/7/21 (2 doses) for moderate/severe right arm and left foot pain.	F 656	care plans for residents with pain, to include non-drug interventions. The DON/designee will review care plans weekly x's 2 months and then monthly for compliance. Areas of concern will be corrected as identified. 4. The results of this monitoring audit will be reported and reviewed at our Quarterly Quality Assurance meeting for one year.	

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F 656	Continued From page 3	F 656		

Resident #1's plan of care (print date 2/10/21) documented the resident had the potential for "alteration in comfort level" due to history of hip fracture/replacement, left foot pain and neuropathy. The care plan listed interventions for pain control as, "Assess response to pain medications...Assess for pain and provide pain relief when needed before activities...Inform MD [physician] as needed...Pre-medicate in anticipation of potentially painful procedure...Medicate as ordered..."

Resident #1's plan of care included no individualized interventions regarding non-drug interventions to minimize pain or any alternates to medication. The care plan made no mention of the resident's right arm/hand pain and failed to list individualized problems and interventions regarding pain.

On 2/10/21 at 9:20 a.m., the licensed practical nurse (LPN #1) that routinely cared for Resident #1 was interviewed. LPN #1 stated Resident #1 frequently requested pain medications for right arm and left foot pain. LPN #1 stated the medications were administered when requested and were usually effective. LPN #1 stated the resident had been offered ice packs, range of motion and encouragement to move about in addition to the medications. LPN #1 stated the resident refused to get out of bed most days.

On 2/10/21 at 10:00 a.m., the registered nurse unit manager (RN #1) responsible for care plans was interviewed about Resident #1's plan. RN #1 stated the resident had neuropathy and frequently complained of burning pain in his left foot and right hand/arm. RN #1 stated nurses attempted non-drug interventions for pain but the resident

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F 656	Continued From page 4 was not always cooperative. RN #1 stated the care plan did not reflect the attempted non-drug interventions such as range of motion, one to one conversation, and encouragement to get out of bed. This finding was reviewed with the administrator and director of nursing on 2/10/21 at 2:30 p.m.	F 656		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		3/5/21

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F 756	Continued From page 5 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to respond to pharmacy recommendations on a monthly Medication Regimen Review (MRR) for one of fourteen residents in the survey sample, Resident #7. The findings include: Resident #7 was admitted to the facility on 9/14/2019. Diagnoses for Resident #7 included, but were not limited to: Adjustment disorder with anxiety and depressed mood, Major depressive disorder single episode, severe with psychotic features, Cellulitis of right lower limb, Chronic atrial fibrillation, Complete traumatic amputation at level between right hip and knee, Orthopedic aftercare following surgical amputation, Essential hypertension, Heart Failure, Low back pain, and Morbid (severe) obesity. The most recent full minimum data set (MDS) was a quarterly assessment dated 1/05/2021. The MDS assessed Resident #7 with a cognitive score of 14, indicating the resident was cognitively intact. Resident #7's clinical record was reviewed on 2/09/2021 through 2/10/2021.	F 756	F 756 1. Resident #7's pharmacy recommendation on the monthly Medication Regimen Review (dated 1/28/21) has been addressed by the facility physician. 2. A chart review of other residents will be completed to assure other monthly MRRs for January have been addressed by the facility physician. 3. The DON/UM/designee will be responsible for monitoring the monthly Medication Regimen Review to assure that any pharmacy recommendations are followed up with by the facility physician and documented in the resident medical record. The DON/designee will monitor that this occurs monthly with appropriate follow up and documentation in each resident's medical record. This monthly review of completion will be submitted to the Executive Director each month. 4. The results of this monitoring audit will be reported and reviewed at our Quarterly Quality Assurance meeting for one year.	

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On 01/28/2021, the MRR for Resident #7 documented a recommendation made by the pharmacist to "review Resident's current condition and consider tapering medication to evaluate if Resident is on the lowest possible dose, or continues to need the medication", for Duloxetine DR (Cymbalta) 40mg once a day and Trazodone 50mg at bedtime. There was no documentation by the facility physician of action taken to address the recommendation. There were no physician's progress notes regarding a review of the MRR dated 1/28/2021.

A review of Resident #7's current physician's order set (POS) documented an order dated 9/28/2020 for: Trazadone 50mg tablet oral every day for major depressive disorder, single episode, severe with psychotic features, and Cymbalta 20mg capsule delayed release (2 caps) Capsule, delayed release (enteric coated) oral one time daily for major depressive disorder, single episode, severe with psychotic features.

A review of Resident #7's medication administration review (MAR) from 2/01/2021 through 2/10/2021 documented the resident had received the above medications and dosage as ordered.

On 2/10/2021 at 2:04 p.m. the director of nursing (DON) was interviewed regarding the facility's procedure for the review of the monthly MRR. The DON stated she was not sure why the physician had not reviewed the recommendations made on the MRR dated 1/28/2021, but that "it should have been done by now and not sure what happened, but we are looking into it."

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F 756	Continued From page 7 No further information or documentation was presented prior to the exit conference on 2/10/2021 at 2:45 p.m. to evidence the facility staff had reviewed the monthly MRR.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure expired vacutainers (blood collection tubes) were not available for use in the facility's medication storage room.	F 761	F 761 1. The expired vacutainers (blood collection tubes) were discarded.	3/5/21

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F 761	Continued From page 8 The findings include: On 2/10/21 at 9:10 a.m., accompanied by the registered nurse unit manager (RN #1), the facility's medication storage room was inspected. Stored and available for use were four expired blood collection tubes with blue tops. The tubes were labeled by the manufacturer as expired on 12/10/20. On 2/10/21 at 9:15 a.m., RN #1 was interviewed about the expired vacutainers. RN #1 stated the blue top tubes were used for PT/INR (prothrombin time/international normalized ratio) tests. RN #1 stated the expired tubes should have been discarded and all nurses were responsible to maintain the medication room with in-date supplies. On 2/10/21 at 11:05 a.m., the director of nursing (DON) was interviewed about the expired vacutainers. The DON stated the night shift nurses were assigned to inspect the medication room daily and discard or remove expired items. The DON stated the facility had no specific policy about vacutainers but staff were expected to discard any expired blood collection tubes. This finding was reviewed with the administrator and DON on 2/10/21 at 2:30 p.m.	F 761	2. Items in the medication storage room will be reviewed for expiration dates. Any items identified as expired will be discarded. 3. Nurses on the unit will be in-serviced by the Unit Manager/designee on the proper monitoring and disposal of items in the medication storage room. The UM/designee will audit the medication storage room weekly x's 2 months and then monthly for compliance. Areas of concern will be corrected as identified. 4. The results of this monitoring audit will be reported and reviewed at our Quarterly Quality Assurance meeting for one year.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		3/5/21

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F 880	Continued From page 9	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 10 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices for COVID-19 prevention for five of 14 residents in the survey sample. Residents #2, #3, #6 and #11 were seated in the day area following a meal without social distancing or face coverings/masks. A nurse failed to use required PPE (personal protective equipment) when entering Resident #215's room during a medication pass observation. The findings include: 1. On 2/9/21 at 9:25 a.m., four residents were observed seated at tables in the day area.	F 880	F 880 1. Residents #2, #3, #6, and #11 will either eat meals in their rooms with proper tray set up/assistance or be socially distanced with face coverings/mask on (when appropriate) when in the day area. Nursing staff are wearing required PPE (personal protective equipment) when entering resident rooms where appropriate. 2. All residents have the potential of being affected by these improper infection control practices. No new confirmed Covid-19 residents have been identified since as of 2/23/2021.	

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F 880	Continued From page 11 Residents #2 and #11 were seated less than 6 feet across from each other at a small round table next to the wall. These residents had no masks or face coverings in use. Breakfast dishes were in front of each resident but neither resident was actively eating. Two additional residents (Residents #3 and #6) were seated at a table near the center of the room. Residents #3 and #6 were less than 6 feet from each other at the small table with no face coverings or masks in use. No staff members were observed in the room. On 2/9/21 at 10:51 a.m., the director of nursing (DON) advised the survey team that Residents #2 and #11 had just tested positive for COVID-19. On 2/9/21 at 2:50 p.m., the director of nursing (DON) was interviewed about resident dining during COVID-19. The DON stated the formal dining area was closed for residents and residents were served meals in their rooms. When asked about the residents in the day area observed on 2/9/21, the DON stated that area was used for residents requiring assistance with meals. On 2/9/21 at 3:00 p.m., the registered nurse unit manager (RN #1) was interviewed about the four residents observed in the day area without social distancing or face coverings. RN #1 stated the residents were in the day area because they required assistance with eating. RN #1 stated Resident #11 required cueing to eat and Resident #6 required feeding by staff. RN #1 stated Residents #2 and #3 were able to feed themselves but required help with cutting up food items and tray set-up. RN #1 stated the residents were supposed to be socially distant and she did	F 880	3. Staff on the unit will be in-serviced by the DON/Infection Control Preventionist/UM on; proper social distancing when a resident may be out of their room to include proper face coverings/mask usage, residents to eat in their room where appropriate, and proper use of required PPE when entering a resident's room where needed. These practices will be monitored by daily random observational audits x's one month and then monitored weekly by random audits by the DON/ICP/UM/Charge nurse throughout the pandemic. Areas of concern will be corrected as identified with further education completed as needed. 4. The results of this monitoring audit will be reported and reviewed at our Quarterly Quality Assurance meeting for two years.	

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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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not know why they were seated together at tables. When asked why the residents did not eat in their rooms, RN #1 stated it was easier for staff to feed the residents in the day area. RN #1 stated, "I really don't know why they [residents] were seated like that." RN #1 stated when residents were out of their rooms they were supposed stay at least 6 feet apart and wear a face covering.

Review of clinical records documented Residents #2, #3, #6 and #11 were assessed with cognitive impairments with three out of the four residents severely impaired.

Resident #2 was admitted to the facility on 1/31/20 with diagnoses that included Alzheimer's, cancer, deep vein thrombosis and anxiety. The MDS (minimum data set) dated 1/12/21 assessed Resident #2 with severely impaired cognitive skills.

Resident #3 was admitted to the facility on 5/5/20 with diagnoses that included COPD (chronic obstructive pulmonary disease), diabetes, dementia, bipolar disorder and depression. The MDS dated 1/19/21 assessed Resident #3 with moderately impaired cognitive skills.

Resident #6 was admitted to the facility on 12/22/15 with diagnoses that included Alzheimer's, anxiety, depression, psychosis and hypertension. The MDS dated 11/17/20 assessed Resident #6 with short and long-term memory problems and severely impaired cognitive skills.

Resident #11 was admitted to the facility on 1/24/18 with diagnoses that included Alzheimer's,

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	495405	A. BUILDING _____ B. WING _____	02/10/2021

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cerebrovascular accident (stroke), dementia, cancer and depression. The MDS dated 12/22/20 assessed Resident #11 with short and long-term memory problems and severely impaired cognitive skills.

The facility's policy titled Pandemic Preparedness and Response Plan (revised 1/26/21) documented under the infection control protocols during a pandemic that the facility "...will implement strict infection control measures to help contain illness..." This policy documented on page 8 that the facility "...will implement social distancing as the primary infection control measure. The following strategies will be employed...Meal service in the dining rooms will be restricted or canceled, and meals will be delivered to residents in their rooms. Residents requiring eating assistance will be supervised by trained staff. Dining services staff will determine the need for, and implement if necessary, staggered tray preparation, delivery and pick-up...If/when residents must gather, individuals should be seated at least six feet apart from each other. In cases where this is not possible, isolation masks will be utilized to avoid interpersonal contamination. Staff will provide particular support to cognitively impaired residents during these gatherings..."

These findings were reviewed with the administrator and DON on 2/9/21 at 4:30 p.m. and on 2/10/21 at 2:30 p.m.

2. A medication pass was conducted on 2/10/21 at 8:15 a.m. with licensed practical nurse (LPN #1) observed administering medications to Resident #215. At the time of this observation, signs were posted on Resident #215's door

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stating the resident was on droplet/airborne precautions and entrance to the room required the following: N95 mask, gown, gloves and eye protection. A box was positioned beside the door entrance with a supply of disposable gloves, gowns and masks.

On 2/10/21 at 8:17 a.m., LPN #1, wearing a cloth gown, face shield and gloves, prepared medicines for Resident #215 then entered the room and administered the oral medicines. On 2/10/21 at 8:21 a.m., wearing the same cloth gown, LPN #1 returned to the medication cart, changed her gloves and prepared another medication for Resident #215 stating the resident requested something for nausea. After preparing this medicine, LPN #1 re-entered Resident #215's room for administration of the nausea medicine. LPN #1 exited Resident #215's room, removed her gloves, returned to the medication cart then used hand sanitizer. LPN #1 did not remove or change her gown upon exit from Resident #215's room and wore the same cloth gown when preparing and administering medications to the next resident (Resident #12) in the medication pass. LPN #1 did not put on a disposable gown prior to either entrance into Resident #215's room.

On 2/10/21 at 8:31 a.m., LPN #1 was interviewed about the PPE required when going in/out of Resident #215's room since it was posted with droplet/airborne precautions. LPN #1 stated staff were supposed to put on a disposable gown prior to entering the room and discard the gown before exiting. LPN #1 stated, "I just forgot to put the gown on." LPN #1 stated Resident #215 was on droplet precautions and 14-day quarantine because she was a new admission. LPN #1

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stated staff were supposed to put on the "extra" gown for those on transmission precautions.

On 2/10/21 at 1:45 p.m., the director of nursing (DON) was interviewed about required PPE for entrance/exit of Resident #215's room. The DON stated Resident #215 was on droplet precautions and 14-day quarantine because she was a new admission. The DON stated staff entering Resident #215's room were supposed to put on a disposable gown and discard the gown prior to exiting the room.

Resident #215's clinical record documented the resident was admitted to the facility on 2/4/21 and placed on 14-day quarantine with droplet/airborne precautions due to COVID-19 prevention protocols.

The facility's policy titled Coronavirus (COVID-19) revised 1/26/21 documented, "...The virus is thought to spread mainly from person to person; between people who are in close contact with one another (within about 6 feet) and or through respiratory droplets produced when an infected person coughs or sneezes..." This policy documented, "New admissions will be placed on quarantine for 14 days."

The facility's policy titled Isolation Precautions (revised 4/10/20) documented, "...Gowns are worn to prevent contamination of clothing and protect the skin of personnel from blood and body fluid exposures...Gowns are single use...Remove and discard gowns prior to leaving patient room...After gown removal, ensure clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other resident's or

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F 880	Continued From page 16 environments..." The facility's policy titled Enhanced Barrier Precautions for Multi-Drug Resistant Organism (MDROs) revised 4/10/20 documented the following PPE for entrance to rooms with droplet/airborne precautions: gloves, gown, N95 mask and eye protection. These findings were reviewed with the administrator and director of nursing on 2/10/21 at 2:30 p.m.	F 880		