STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated survey was conducted 3/22/22 through 3/23/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints (VA00054704 substantiated with deficiency, VA00054689 substantiated with deficiency, and VA00052708 substantiated with deficiency) were investigated during the survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care and services in accordance with professional standards for two Residents (Resident #2, Resident #5) in a sample size of 6 Residents. The findings included: 1. For Resident #2, the facility staff failed to administer medications, tube feeding/flushes, and check blood glucose levels as ordered by the physician on 03/05/2022. On 03/22/2022 and 03/23/2022, Resident #2's clinical record was reviewed. A physician's order dated 02/17/2022 documented, "Enteral Feed	F 658	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 658 1. Resident #2 MD and Responsible	4/20/22

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

Electronically Signed | 04/07/2022

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F 658	Continued From page 1 Order every shift Jevity 1.5 @ 50ml/hr [50 milliliters per hour] continuous via PEG [percutaneous endoscopic gastrostomy tube] (may hold for 1-2hrs/daily for ADLs etc.)[may hold for 1-2 hours daily for Activities of Daily Living]" A review of the Medication Administration Record revealed that the Jevity was not signed off as administered on 03/05/2022 for the day shift. A physician's order dated 02/25/2022 documented, "Enteral Feed Order every 6 hours for water flush 150ml [150 milliliters] water flush 4x [4 times] daily via PEG." A review of the Medication Administration Record revealed that the water flush was not signed off as administered on 03/05/2022 at 12:00 P.M. and 6:00 P.M. A physician's order dated 02/17/2022 documented, "Zenpep Capsule Delayed Release Particles 40000-126000 UNIT (Pancrelipase (Lip-Prot-Amyl)) Give 2 capsule via PEG-Tube with meals for exocrine pancreatic insufficiency." A review of the Medication Administration Record revealed that Zenpep was not signed off as administered on 03/05/2022 at 12:00 P.M. A physician's order dated 02/17/2022 documented, "Coreg Tablet 3.125 MG (Carvedilol) Give 1 tablet via PEG-Tube two times a day for hypertension." A review of the Medication Administration Record revealed that Coreg was not signed off as administered on 03/05/2022 at 6:00 P.M. A physician's order dated 03/01/2022 documented, "LORazepam Tablet 0.5 MG Give 0.5 tablet by mouth two times a day for anxiety/agitation." A review of the Medication	F 658	party have been made aware of missed medications, tube feed flushes and glucose monitoring levels on 3/5/22. B. Resident #5 abdominal binder has been discontinued. Gastrostomy tube anchor is in place. 2 Current residents in the center with medication /tube feed/blood glucose orders have the potential to be affected. b. Residents with orders for abdominal binders /gastrostomy tube anchors have the potential to be affected 3. Director of nursing/designee will educate Licensed nurses on medication /treatment administration and documentation, following physician orders including the placement of abdominal binder/gastrotomy tube anchor. 4. Director of nursing/ designee will review missed documentation of medication /treatment orders daily on 10 random patients. Weekly audit of patients with gastrostomy tubes to ensure placement /documentation of anchor /abdominal binder as ordered. Results will be reported to the Monthly Quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, review will be completed on a random basis. 5. Date of compliance 4/20/22	

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Administration Record revealed that lorazepam was not signed off as administered on 03/05/2022 at 6:00 P.M.

A physician's order dated 02/22/2022 documented, "Blood sugars every 6 hours for blood glucose management." A review of the Medication Administration Record revealed that the blood sugar levels were not obtained on 03/05/2022 at 12:00 P.M. and 6:00 P.M. resulting in an 18-hour lapse of monitoring Resident #2's blood glucose level.

A physician's order dated 02/25/2022 documented, "Insulin NPH (Human) (Isophane) Suspension 100 UNIT/ML Inject 19 unit subcutaneously two times a day for diabetes." A review of the Medication Administration Record revealed that the insulin WAS administered on 03/05/2022 at 7:30 A.M. and 4:00 P.M. even though the blood glucose levels had not been monitored as ordered and the enteral feeding was not signed off as administered for the day shift.

On 03/23/2022 at 10:30 A.M., Licensed Practical Nurse D (LPN D) was interviewed. LPN D verified she was Resident #2's nurse on 03/05/2022 and reported for work at approximately 2:00 P.M. This surveyor and LPN D observed Resident #2's electronic Medication Administration Record. When asked why Resident #2 did not receive the medications and blood glucose level monitoring during her shift on 03/05/2022 as ordered by the physician, LPN D indicated she didn't know and stated she "should have written a note why they weren't done." LPN D also stated that if she gave them, she would have documented it.

The progress notes for Resident #2 for

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03/05/2022 were reviewed. There was one progress note written on 03/05/2022 and it was written by LPN D. The progress note was dated 03/05/2022 at 6:15 P.M. which documented, "Resident refused weight." There was no documentation addressing why the medications and blood glucose monitoring were not signed off as administered as ordered.

On 03/23/2022 at 11:25 A.M., the administrator and Director of Nursing were notified of findings. When asked about the facility's professional standards reference, the DON stated it was Lippincott. According to Lippincott's "Nursing 2018 Drug Handbook" under the section entitled, "Insulins (intermediate-acting) (NPH)" and sub-header "Nursing Considerations" an excerpt documented, "Monitor blood glucose levels..." According to Lippincott "Nursing Procedures", Seventh Edition, 2016, under the section entitled, "Oral Drug Administration" steps in the implementation process included but were not limited to: "Verify the medication is being administered at the proper time ...to reduce the risk of medication errors." In the section entitled, "Blood Glucose Monitoring" steps in the implementation process included but not limited to: "Verify the practitioner's order." Under the sub-header "Documentation" an excerpt documented, "Record the date and the time of testing and results in the patient's medical record."

On 03/23/2022, the facility staff provided a copy of their policy entitled, "Blood Testing Monitoring." Under the header, "Policy", it was documented, "Licensed nurses will complete blood glucose monitoring as ordered by the physician or when emergency situations indicate the need."

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F 658	Continued From page 4 On 03/23/2022 at approximately 2:45 P.M., the administrator and Director of Nursing stated there was no further information or documentation to submit. 2. For Resident #5, the facility staff failed to: a) Apply an abdominal binder as ordered by the physician b) Apply a feeding tube anchor as ordered by the physician. c) Maintain a clean feeding tube site on 03/23/2022. On 03/23/2022, Resident #5's clinical record was reviewed. A physician's order dated 06/21/2021 documented, "Apply abdominal binder and check placement q [every] shift." A review of the Treatment Administration Record for March 2022 revealed that the application of the abdominal binder was not located on the Treatment Record. A physician's order dated 06/17/2021 documented, "Anchor feeding tube every shift." A review of the Treatment Administration Record for March 2022 revealed that the application of the feeding tube anchor was signed off as administered on each shift in March 2022 with the exception of the following: Day shift on 03/01/2022, 03/11/2022, 03/14/2022, 03/15/2022, and 03/16/2022; evening shift and night shift on 03/21/2022. There was not a physician's order for feeding tube site care or dressing.	F 658		

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On 03/23/2022 at 9:25 A.M., this surveyor and Licensed Practical Nurse C (LPN C) entered Resident #5's room to observe Resident #5's feeding tube. LPN C lifted Resident #5's covers and gown to reveal the enteral feeding tube site. Resident #5 did not have an abdominal binder on as ordered by the physician; there was no dressing applied to the feeding tube site; and there was no feeding tube anchor observed. There were dried, brownish chunks of a substance observed under the external bumper of the feeding tube and surrounding skin. When asked what the dried, brown substance was, LPN C stated it looked like old feeding solution. LPN C went to gather supplies and returned to Resident #5's room. LPN C cleaned the site and surrounding skin with a dermal wound cleanser and applied a gauze dressing at the site. After exiting the room at approximately 9:45 A.M., LPN C was asked about the abdominal binder. LPN C referred to the physician's orders and verified there was an order for the abdominal binder but it wasn't listed on the Treatment Record. LPN C then checked Resident #5's room for an abdominal binder but was not able to locate it. When asked about the feeding tube anchor, LPN C stated she was not able to apply a feeding tube anchor because the facility does not have PEG tube anchors, only gastrostomy tubes (G-tube) anchors.

On 03/23/2022 at 11:25 A.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about the facility's professional standards reference, the DON stated it was Lippincott. According to Lippincott "Nursing Procedures", Seventh Edition, 2016, under the section entitled, "Transabdominal Tube Feeding and Care" and sub-header "Caring for a

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F 658	Continued From page 6 PEG...site" an excerpt documented, "The exit site of a percutaneous endoscopic gastrostomy (PEG)....tube requires routine observation and care." At 12:20 P.M., the DON provided a copy of the facility's policy entitled, "Care of the Patient with a Feeding Tube." An excerpt of Section 1 entitled, "Stoma Care: Gastrostomy ..." documented, "Gastrointestinal stoma site care will be cleaned and a dressing applied as indicated by a licensed nurse in accordance with physician orders." At 12:45 P.M., the DON was notified there were no orders for feeding tube site care for Resident #5. On 03/23/2022 at approximately 2:45 P.M., the administrator and DON stated there was no further documentation or information to submit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide bathing care for one dependant Resident, (Resident #1) in a survey sample of 6 residents. The findings included: For Resident #1, the facility staff failed to provide baths and or showers twice weekly as per facility	F 677	F 677 1. Resident #1 is receiving care and services needed to maintain good hygiene. 2. Current residents in center have the potential to be affected 3. Director of Nursing or designee will educate all Licensed nurses on correctly entering resident bathing schedule in point click care and monitoring to ensure bathing schedules are adhered to.	4/20/22

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F 677	Continued From page 7 policy and Resident preference. On 3/22/22 during initial tour of the facility, Resident #1 was interviewed in her room. Observation of the Resident revealed that the Resident's hair was matted in the back, and oily in appearance. The Resident was found to be pleasant, smiling, attentive, and talkative. The Resident was oriented to self, place, and was appropriate in response to questioning. The Resident complained that the Resident's hair was too long and very uncomfortable. Resident #1 verbalized that the Resident "have not had a bath since last year, they don't have enough people to give baths every day they tell me". The Resident's feet were observed uncovered with the Resident laying in bed, and of note were scaling, thick, square pieces of yellow skin, sloughing off on the sheet beneath the Resident's feet. The skin under the sloughing dead skin was pink and soft. There was no swelling of the extremities, and her legs were pink and unblemished. The Resident's family member was at the bedside. On 3-22-22 at 1:00 p.m., a CNA on the Resident's unit was interviewed and asked if she had given care to Resident #1, she stated she had in the past but not that day. She was asked if she bathed the Resident, and she stated no, that she was from an outside agency and could give no account of the Resident as she had "not worked with [the resident] much." Other staff on the unit identified themselves as "agency staff" and they stated "I don't really work with [the resident] much." A full review of the Resident's clinical record was conducted, and revealed that the Resident was incontinent of bowel and bladder, and dependant	F 677	4. Director of nursing /designee will audit bathing documentation on 5 random patients per week to ensure bathing has occurred. 5. Results will be reported to Monthly Quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines problem no longer exists review will be completed on a random basis. 6. Date of compliance 4/20/22	

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on staff for all bathing and incontinence care.

The interdisciplinary progress notes revealed no refusal of care.

The Care plan for Resident #1 was reviewed and revealed no care planning for bathing.

On 3/22/22 at approximately 4:00 p.m., the surveyor asked where the hygiene and bathing records could be found and they responded that CNA's document in the computerized point of care software program located in cabinets on each hallway. The surveyor requested bathing records for the Resident for the month of March 2022, at the end of day debrief with the Administrator, Director of Nursing (DON), and the Corporate Regional Registered Nurse Consultant. The DON was asked her expectation of how often Residents should be bathed weekly. The DON responded "Twice weekly, with hygiene and incontinence care after each incontinent episode." They were asked if the documents reflected care given, and stated that if it's not documented it's not done.

The Resident's "point of care" documentation completed by CNA's (certified nursing assistants) for ADL (activities of daily living) care such as bathing and hygiene that included incontinence episode care was reviewed. The documents revealed, that the Resident received hygiene for the entire 24 hours per day, 22 day period as follows;

twice on 3/2/22
twice on 3/3/22
once on 3/4/22
twice on 3/5/22

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F 677	Continued From page 9 once on 3/8/22 once on 3/10/22 once on 3/11/22 once on 3/12/22 twice on 3/13/22 once on 3/17/22 twice on 3/19/22 twice on 3/20/22 once on 3/21/22 and once on 3/22/21 20 occurrences of hygiene were given for the Resident in 22 days. No bath, nor showers were documented as given for the entire 22 day period from 3/1/22 through the time of survey on 3/22/22. The DON was asked what the facility policy was for bathing and incontinence care, she stated "baths or showers twice weekly, and incontinence care after each incontinence episode." A bathing and incontinence care facility policy was requested on 3 occasions, and never received. On 3/23/22 at 3:00 PM, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided. Complaint related deficiency.	F 677		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		4/20/22

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F 806	Continued From page 10 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility documentation review the facility staff failed to honor food preferences for one resident in a sample size of seven residents. The findings included: During an interview on March 22, 2022, at approximately 2:30 p.m. Certified Nursing Assistant (CNA) A was observed to be removing Resident #7's tray. Resident tray revealed a meal consumption of less than 25%. CNA A stated that the resident likes peanut butter and jelly sandwiches and will ask dietary for a peanut butter and jelly sandwich for resident #7. The Surveyor accompanied CNA A to the kitchen with the partially consumed meal tray. CNA A was greeted at the entrance, of the kitchen, by Staff H. CNA A requested a peanut butter and jelly sandwich from Staff H. Staff H departed and returned to inform CNA A there was only ham and cheese sandwiches available. At approximately 3 p.m. Surveyor A and Surveyor B interviewed Staff G in the kitchen. Staff G showed the surveyors the resources (peanut butter, jelly) on shelf that were needed to prepare a peanut butter and jelly sandwich. The dietary	F 806	F 806 1. Resident #7 is receiving food to meet his preferences. 2. Current residents in the center have the potential to be affected 3. Dietary Services will be educated by the Regional Dietary Manager or Designee to assess and provide residents with food preferences. 4. The Unit manager/ Designee will complete 5 resident interviews weekly to ensure food preferences have been provided. 5. Results will be reported to the Monthly Quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, review will be completed on a random basis. 6. Date of compliance 4/20/22	

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F 806	Continued From page 11 manager asked which staff member stated there was no peanut butter and jelly sandwiches available. Surveyor A identified Staff H. Staff G asked Staff H the basis of not fulfilling the request for the peanut butter and jelly sandwich. Staff H verbalized that their focus was on another task (dishes). Surveyor B asked Staff H if making sandwiches was a part of job role. Staff H responded, yes. The facility provided a copy of policy (Dining and Food Preferences) dated October 2019. The Dining and Food Preferences Policy stated "upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value." The Administrator and Director of Nursing were notified of findings on 03/23/22 at approximately 2 p.m.	F 806		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		4/20/22

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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(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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§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19

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vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the

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F 888	Continued From page 14 contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure 100% compliance for staff primary vaccination against COVID-19. One staff member was found to have no Primary COVID-19 vaccinations. There were no COVID-19 positive residents nor COVID-19	F 888	F 888 1. Employee has not returned to work since 3/23/22 2. Current residents in the center have potential to be affected. 3. The Director of nursing/designee will educate the Human Resources Manager and Infection Preventionist on	

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F 888	Continued From page 15 positive staff in the facility during the survey. There were 149 total staff and 148 staff were completely vaccinated for a vaccination percentage rate of 99.3. There were no staff exemptions. The findings included: For Employee (H) no primary vaccination series that was completed for COVID-19. Prior to the survey commencement, surveyors reviewed the Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) website and found the facility name and the self reported staff vaccination record. The facility self reported as 100% compliant with primary vaccination completion for all staff with no waivers and no partial vaccinations. Employee (H) was added to the staff sample of known employees observed to be working with residents and staff during the onsite survey. While reviewing facility vaccination records, Employee (H)'s name did not appear on the facility staff record. The Administrator was asked to supply the vaccination record for Employee (H), and also to correct the employee record to include all staff as was requested at the entrance conference. The Administrator returned on 3-23-22 and stated that Employee (H) had no vaccinations, nor record. The Administrator was made aware of the deficient practice and stated she would correct the self report to the NHSN website immediately. The Administrator stated she had no further information to provide at the time of exit	F 888	requirement to verify and document staff vaccination status prior to working in center. 4. The administrator/ designee will audit new hires for vaccination status prior to working in center. 5. Results will be reported to the Monthly Quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, review will be completed on a random basis. 6. Date of compliance 4/20/22	

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