STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495274	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA 24017

(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 COVID-19 Focused Survey (F0024) was conducted onsite on 6/25/2020 and 6/26/2020. Emergency Preparedness information had also been reviewed off site 6/25/2020 through 7/1/2020. 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 COVID-19 Focused Infection Control Survey was conducted on 06/25/2020 and 6/26/2020.. Infection Control information had also been previously reviewed off site on 6/25/2020 through 7/1/2020. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 06/26/2020, the census in this 180 certified bed facility was 165 . Of the 165 current residents, 8 residents had tested positive for the COVID-19 virus. The survey sample consisted of 7 current resident reviews (Residents #1 through Resident #7.)	F 000		
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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		8/12/20

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

Electronically Signed | 07/31/2020

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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F 880	Continued From page 1 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 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	F 880		

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F 880	Continued From page 2 (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 observations, staff interviews, clinical record review, facility documentation review, and during the course of a COVID-19 focused survey, it was determined the facility staff failed to consistently implement infection control plans/practices designed to attempt to prevent the development and/or transmission of COVID-19 involving 2 out of 7 residents in the survey sample as evidence by failure to implement face coverings for a resident with known exposure to COVID while seated with a group of residents; failure to implement transmission based precautions for residents with known exposure to COVID-19; failure to have PPE readily accessible for staff caring for residents with COVID-19; and failure to appropriately handle linen from a COVID positive room. The findings included: 1. The facility staff failed to implement	F 880	Preparation and submission of the plan of correction does not constitute an admission or agreement by the provider of the truths of the conclusions alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. #1: 1. Resident #3 tested negative and had remained asymptomatic from the testing date 8 days prior, while sharing a room with a now positive COVID-19 resident. He had received monitoring every shift during the 8 day waiting period, with no indications of COVID-19 and retested with a negative result. He was not placed on precautions, including the requirement to wear a face covering.	

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F 880	Continued From page 3 interventions of face coverings for Resident # 3 who had been exposed to COVID-19, and was observed seated in the day room with a group of residents. On 6/25/20 at 10:45 am, an entrance conference was conducted with the assistant administrator, director of nursing (DON), assistant director of nursing (ADON), and the QI (quality improvement)/regulatory nurse. During this entrance conference, the assistant administrator informed the survey team that the facility staff had tested 178 residents and 239 facility staff members, and that the facility staff had been made aware via telephone that morning (6/25/20), that 8 facility residents and 6 facility staff members had tested positive for COVID-19. The assistant administrator had also informed the survey team there were 6 COVID-19 test results that were still pending and that the identity of the 6 pending test results were unknown. Therefore, the pending COVID-19 test results could belong to any resident or facility staff member. Resident # 3 has diagnoses that included but were not limited to, dementia, type 2 diabetes mellitus, and hypertension. Resident # 3's roommate tested positive for COVID-19 on 6/25/20, therefore Resident # 3 had been exposed to COVID-19. The most recent MDS (minimum data set) assessment for Resident # 3 was a quarterly assessment with and ARD (assessment reference date) of 6/16/20. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 3 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that	F 880	2. All residents on the unit had the potential to be exposed to positive COVID-19 residents during the 8 day waiting period. 3. The policy is updated to reflect that residents who tests negative but was exposed by the roommate will be placed on precautions, including the requirement to wear a face covering when outside of their room, if at all possible and the need to socially distance. These residents will be considered 'WARM' COVID cases, and will stay on precautions for 14 days from last exposure date or until a new negative test result occurs. Since not all residents can medically comply with face covering requirements, resident care plans will be adjusted to address those that are cognitively impaired or oxygen dependent and will not be able to follow the requirements. All other residents will have a face covering offered daily, and documentation completed if they decline. Staff have been educated on the policy changes and documentation requirements by Staff Development or designee. 4. The DON/ADON or designee will monitor and audit resident face covering compliance when positive COVID-19 cases are in the facility, and 'warm' cases are being monitored. Compliance will be reported to the QI Committee for review. 5. Date of compliance: August 12, 2020	

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F 880	Continued From page 4 Resident # 3's cognitive status was severely impaired. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 3 was totally dependent of staff, requiring the assistance of one person for locomotion on the unit. The plan of care for Resident # 3 was reviewed and revised on 3/18/20. The facility staff documented a focus area for Resident # 3 as, "Risk of exposure/transmission COVID-19." Interventions included but were not limited to, "Educate resident on social distancing with no handshakes, hugging, communal dining, and group activities," and "Provide facemask if the resident must leave the room for medically necessary transfer out of the facility." On 6/25/20 at 11:30 am, the surveyor conducted observations on the 2-west unit. The surveyor observed a group of 11 residents seated out in the day room area around the television. The surveyor observed that none of the residents were wearing face coverings or facemasks. The surveyor noted Resident # 3 to be one of the 11 residents in the group in the day room area around the television. Resident # 3 was seated in a broada chair, and did not have a face covering or face mask. The surveyor also observed 2 residents ambulate independently and one resident self propel via wheelchair independently without face coverings, and the 3 residents observed were within 6 feet of Resident # 3. The surveyor did not observe a staff member attempt to offer a facemask or face covering to any of the residents seated in a group in the day room area. The surveyor also did not observe any staff member attempt to provide interventions to promote social distancing when residents were	F 880	#2: 1. Resident #3 and #4 tested negative and had remained asymptomatic from the testing date 8 days prior, while sharing a room with a now positive COVID-19 resident. They had received monitoring every shift during the 8 day waiting period, with no indications of COVID-19 and retested with a negative result. They were not placed on precautions at the time the results were identified. 2. All residents on the unit had the potential to be exposed to positive COVID-19 residents during the 8 day waiting period. 3. The policy is updated to reflect that residents who tests negative but was exposed by the roommate will be placed on transmission based precautions (Contact/Droplet Precautions), including the requirement to wear a face covering when outside of their room, if at all possible and the need to socially distance. These residents will be considered 'WARM' COVID cases, and will stay on precautions for 14 days from last exposure date or until a new negative test result occurs. Staff have been educated on the policy changes by Staff Development or designee. 4. The Infection Preventionist or designee will monitor and audit the precautions status of all COVID-19 positives (HOT) and suspected (WARM), for appropriate precaution steps, equipment and PPE. Daily Infection Control rounds will be	

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F 880	Continued From page 5 within 6 feet of Resident # 3. The facility "Outbreak Management" plan contained documentation that included but was not limited to, ..."C. Restrictions vii. Limit group activities and outings, if so directed by the administrator (or designee)." ... The facility policy on "Transmission Based Precautions" contained documentation that included but was not limited to, ..."4. Specific precaution advise n. Droplet Precautions - Resident MUST wear a mask when out of room or during transportation to outside appointments." ... The facility "Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID19" contained documentation that included but was not limited to, ..."Elements to be assessed If residents leave their rooms, they should wear a cloth face covering or facemask (if tolerated), perform hand hygiene, limit movement in the facility, and perform social distancing." ... The surveyor observed a handwritten check mark next to "Yes" for "Assessment" in this area. In the "Notes/Areas for Improvement" block in this area, the surveyor observed handwritten documentation that stated "Except for those who will not tolerate mask, and those on memory care unit." ... On 6/26/20 at 1:32 pm, the surveyor made the administrator and director of nursing aware of the findings as stated above. The surveyor asked the administrator and the director of nursing if it was acceptable for a resident that had been exposed	F 880	conducted for compliance by the Infection Preventionist or designee. Staff re-education will be completed just-in-time when identified by Infection Preventionist or designee. Audit data will be reported to the QI Committee for review. 5. Date of compliance: August 12, 2020 #3: 1. Resident #4 had a positive test result and was being processed to move to the COVID unit. Three residents on this unit had positive test results and were all being processed at this time. PPE items were obtained to facilitate the move. 2. All residents on the unit have the potential to be affected by PPE limitations and access to PPE. 3. The COVID unit was stocked with a high volume of PPE in preparation for any COVID transfers. The PPE items that were needed were obtained within 3 minutes. While trying to conserve PPE stock, per CMS recommendations, vital PPE items were maintained in a secured room nearby. Each unit will have 2 PPE Isolation Set-up bags that will contain all the basic needs to prepare a room and allow staff ready access while complying with PPE requirements. COVID-19 required PPE, per facility policy, does require eye protection in the form of face shield or goggles. Staff re-education will be completed by Staff Education or designee to reinforce all	

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F 880	Continued From page 6 to COVID-19 to be seated in an area with a group of other residents without a face covering. The administrator stated, "We constantly ask residents to wear masks." "They refuse." "There is nothing in the regulations require us to force them to wear a mask." "We had no positive results until the recent test and they were all asymptomatic." On 6/29/20 at 8:00 am, the surveyor reviewed the clinical record for Resident # 3. The surveyor did not observe documentation in the clinical record for Resident # 3 that indicated that facility staff had attempted to provide face coverings to Resident # 3 and there was no documentation observed in the clinical record that Resident # 3 had refused to wear face coverings. On 6/30/20 at 2:47 pm, the survey team spoke with the administrator and director of nursing. The survey team informed the director of nursing and the administrator that the clinical record for Resident # 3 was reviewed and that the surveyor did not observe documentation that the facility staff attempted to provide a face mask or face covering to Resident # 3, nor did the clinical record show documentation that Resident # 3 refused to wear a face mask. The surveyor asked the administrator and the director of nursing why Resident # 3, a resident with known exposure to COVID-19 did not droplet precautions initiated, and was allowed to be seated in an area with a group of residents with no face covering since at the time of the observation, the facility still had 6 pending COVID-19 test results outstanding and the identity of those with pending results was unknown. The administrator stated to the survey team, "Up until now, I felt we were doing everything right." I am not disagreeing with you,	F 880	required PPE items when interacting with a positive COVID-19 case. 4. The Infection Preventionist or designee will ensure that PPE is readily accessible when needed for positive COVID-19 cases as well as other Transmission-Based Precautions. During daily Infection Control rounds, adequate PPE supplies will be audited. Compliance will be reported to the QI Committee for review. 5. Date of compliance: August 12, 2020 #4: 1. CNA#3 failed to comply with the facility policy for COVID laundry. 2. All residents on the unit have the potential to be affected by staff failure to follow Infection Control policies. 3. The staff member in question understood the basics of COVID laundry handling. She inadvertently placed the dirty laundry in a biohazard bag. Nursing staff had been educated on COVID policies but this was the first positive COVID-19 test results in the facility. Re-education on COVID policies for all staff will be needed. We will initiate Positive COVID transfer drills. The Infection Preventionist or designee will focus on education of policy changes and updates, as well as identification of improvement processes.	

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F 880	Continued From page 7 and we will definitely do some things differently moving forward." No further information regarding this issue was presented to the survey team prior to the exit conference on 7/1/20. 2. The facility staff failed to implement appropriate transmission based precautions for 2 of 7 residents in the survey sample that had been exposed to COVID-19 Resident # 3 and Resident # 4. Resident # 3 had diagnoses that included but were not limited to, dementia, type 2 diabetes mellitus, and hypertension. Resident # 3's roommate tested positive for COVID-19 on 6/25/20, therefore Resident # 3 had been exposed to COVID-19. The most recent MDS assessment for Resident # 3 was a quarterly assessment with and ARD of 6/16/20. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 3 had a BIMS score of 5 out of 15, which indicated that Resident # 3's cognitive status was severely impaired. The current plan of care for Resident # 3 was reviewed and revised on 3/18/20. Facility staff documented a focus area for Resident # 3 as, "Risk for exposure/transmission COVID-19." Interventions included but were not limited to, "Implement standard, contact, and droplet precautions for symptoms/undiagnosed respiratory infections; follow facility policy." Resident # 4 had diagnoses that included but	F 880	4. The DON/ADON or designee in collaboration with the Infection Preventionist will conduct audits of compliance and conduct the COVID drills. Just-in-time education will be conducted as needed. Audit data will be reported to the QI Committee for review. 5. Date of compliance: August 12, 2020	

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were not limited to, chronic obstructive pulmonary disease, atrial fibrillation, and hypertension. Resident # 4's roommate tested positive for COVID-19 on 6/25/20, therefore Resident # 4 had been exposed to COVID-19.

The most recent MDS for Resident # 4 was a significant change 5-day Medicare assessment with an ARD of 6/11/20. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 4 had a BIMS score of 13 out of 15, which indicated that Resident # 4 was cognitively intact.
The current plan of care for Resident # 4 was reviewed and revised on 3/18/20. Facility staff documented a focus area for Resident # 4 as, "Risk for exposure/transmission COVID-19." Interventions included but were not limited to, "Implement standard, contact, and droplet precautions for symptoms/undiagnosed respiratory infections; follow facility policy."

On 6/26/20 at 11:51 am, the surveyor observed Resident # 3 sitting in a broada chair in his/her room. The surveyor did not observe any signage on Resident # 3's door or personal protective equipment (PPE) that indicated that Resident # 3 was on any type of transmission based precautions.

On 6/26/20 at 11:53 am, the surveyor observed Resident # 4 sitting in a wheelchair in his/her room. The surveyor did not observe any signage on Resident # 4's door or PPE that indicated that Resident # 4 was on any type of transmission-based precautions.

On 6/26/20 at 12:06 pm, the surveyor conducted an interview with CNA #1 (certified nursing

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assistant). The surveyor asked CNA #1 what type of monitoring was being done for residents exposed to COVID-19. CNA # 1 informed the surveyor that residents were kept in their room unless they needed special attention, and then they would be placed up front in the day area and distanced apart. CNA # 1 informed the surveyor that residents' temperatures were checked twice a shift. Once when they came on shift, and again before the shift was over. The surveyor asked CNA # 1 if he/she wore any additional PPE other than masks and gloves when caring for residents that had been exposed to COVID-19. CNA #1 informed the surveyor that he/she did not wear additional PPE other than mask and gloves when caring for residents that had been exposed to COVID-19 because their tests had come back negative. The surveyor asked CNA #1 how he/she know that the test had come back negative. CNA #1 stated that he/she did not know for sure but assumed that the test had been negative because all of the positive people had been moved to the first floor. The surveyor asked CNA # 1 if he/she was aware that there were COVID-19 test results that were still pending, and that those results could belong to any resident or staff member in the building. CNA # 1 stated that he/she was not aware that there were COVID-19 test results that were still pending.

On 6/26/20 at 1:32 pm, the surveyor made the administrator and director of nursing aware of the findings as stated above. The surveyor asked the administrator and the director of nursing why transmission based precautions had not been implemented for Resident # 3 and Resident # 4 since they had been exposed to COVID-19 when their roommates tested positive, and there were still 6 pending COVID-19 tests results. The

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identity of those pending results were unknown, therefore any of the facility residents or staff could return with a positive result. The director of nursing informed the surveyor that the facility staff was completing full assessments every shift and assessing vital signs on the residents.

On 6/29/20 at 8:10 am, the surveyor reviewed the clinical records for Resident # 3 and Resident # 4. The surveyor did not observe any current or discontinued orders for transmission based precautions for Resident # 3 and Resident # 4.

The facility policy on "Transmission Based Precautions" contained documentation that included but was not limited to,
..."Suspected COVID-19 residents will be moved to a private isolation room and placed on Droplet Precautions until cleared or confirmed." ...
On 6/30/20 at 2:47 pm, the administrator and director of nursing were made aware of the findings as stated above. The administrator stated to the survey team, "Up until now, I felt we were doing everything right." I am not disagreeing with you, and we will definitely do some things differently moving forward."
No further information regarding this issue was presented to the survey team prior to the exit conference on 7/1/20.

3. The facility staff filed to have PPE readily accessible and failed to wear appropriate PPE into a room of a COVID positive resident.

On 6/25/20 at 11:37 am, the surveyor was conducting observations on the 2-west unit. The surveyor observed signage for "Contact Precautions" and "Droplet Precautions" on the door of room of Resident # 4. The surveyor did

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VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA 24017

(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 880	Continued From page 11	F 880		

dot observe any type of isolation cart containing PPE near the room.
On 6/25/20 at 11:40 am, the surveyor observed signage for "Contact Precautions" and "Droplet Precautions" on the door of room of Resident # 3. The surveyor did dot observe any type of isolation cart containing PPE near the room.
The surveyor interviewed the assistant director of nursing (ADON). The surveyor asked the ADON if the resident in room 203 was on isolation precautions. The ADON stated, "Yes, we are in the process of taking the residents down to the COVID unit." The surveyor sked the ADON where the PPE was for staff to utilize when caring for the resident. The ADON stated, "We will have to go down to central supply to get PPE." The surveyor asked the ADON, "If your residents need assistance prior to being transferred to the COVID unit, they will have to wait for someone to go to central supply to get PPE before they can be assisted?" The ADON stated, "Yes." The surveyor observed the ADON leave the unit at that time.
On 6/25/20 at 11:43 am, the surveyor observed the 2-west unit manager leave the unit. On 6/25/20 at 11:46 am, the surveyor observed the 2-west unit manager return to the unit with disposable gowns in hand.

On 6/25/20 at 11:47 am, the surveyor observed 2-west unit manager and LPN #1 (licensed practical nurse) don disposable gowns and gloves. 2-west unit manager and LPN # 1 already had facemask on. The surveyor did not observe 2-west unit manager and LPN # 1 apply a face shield or goggles prior to entering Resident # 4's room.

On 6/25/20 at 2:31 pm, the survey team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495274	A. BUILDING _____ B. WING _____	07/01/2020

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VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA 24017

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F 880	Continued From page 12	F 880		

interviewed the facility infection preventionist. The surveyor asked the infection preventionist if facility staff were expected to wear goggles or a face shield when caring for residents with a diagnosis of COVID-19. The facility infection preventionist informed the survey team that facility staff are expected to wear goggles or a face shield when caring for residents diagnosed with COVID-19.
The facility policy on "Transmission Based Precautions contained documentation that included but was not limited to,
..."2. Implementation
e. All licensed nurses are responsible for ensuring that Transmission-Based Precautions are correctly implemented and that supplies are in place as required." ...
The facility staff provided the survey team with educational material that had been reviewed with facility staff dated 2/27/20. The educational materials contained documentation that included but was not limited to,
..."WHO NEEDS PPE:
Healthcare personnel should adhere to Standard, Contact, and Airborne Precautions including the use of eye protection (e.g., googles or a face shield) when caring for patients with SARS-Co V-2 infection." ...
On 6/26/20 at 1:32 pm, the surveyor made the administrator and director of nursing aware of the findings as stated above.
No further information regarding this issue was presented to the survey team prior to the exit conference on 7/1/20.

4. The facility staff failed to appropriately handle linen from a COVID positive resident.

On 6/25/20 at 1:29 pm, the surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495274	A. BUILDING _____ B. WING _____	07/01/2020

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F 880	Continued From page 13 CNA # 3 enter Resident # 3's room wearing a gown, mask, and gloves. The facility staff had recently transferred the Resident # 3's roommate to the COVID positive unit on the first floor. The surveyor observed CNA # 3 strip Resident # 3's roommate's bed and place the linen in a red biohazard bag following the instruction of the 2 west unit manager. The facility policy for "Laundry COVID 19" contained documentation that included but was not limited to, ...Procedure 4 COVID-19 positive laundry will be placed in the wash in the yellow laundry bags, inverted without touching the contents." ... On 6/26/20 at 1:32 pm, the surveyor made the administrator and director of nursing aware of the findings as stated above. The administrator and director of nursing agreed that COVID positive linens should have been placed in a yellow bag. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/1/20.	F 880		