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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/11/22 through 10/13/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	This Plan of Correction is our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 10/11/22 through 10/13/22. One complaint was investigated during the survey VA00053548 substantiated no deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 119 at the time of the survey. The final sample consisted of 24 current resident reviews and 3 closed record reviews.	F 000	**F 756 (12VAC 5-371-300 (B))** **Corrective Action(s):** The facility immediately notified the facility's Medical Director of the findings from the surveying team. The facility reviewed the recommendations from the drug regimen review with the Medical Director and consideration for change occurred. **Identification of Deficient Practices/Corrective Action(s):** Other residents throughout the facility may have been affected; therefore, the DON, ADON, and Unit Managers have performed an audit of all other residents on the same day of the findings of resident #75 and #37. Any resident who was noted as having an incomplete drug regimen review were discussed and consideration for change was given. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's medical records employee will ensure all forms are complete prior to having both the Medical Director and DON review and sign. **Monitoring:** The DON will be responsible for monitoring compliance. To assist with compliance monitoring, the DON, or designee, will perform monthly drug regimen review audits. The DON will be responsible for implementing additional education, disciplinary action, and process changes to ensure compliance is maintained. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	11/7/2022
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,	F 756		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandon S. Evans
TITLE: Executive Director of Health Services
(X6) DATE: 11/3/22

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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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 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, clinical record review, and facility document review, the facility staff failed to ensure drug regimen reviews were acted upon for 2 of 5 residents in the survey sample reviewed for unnecessary medications, Resident #75 and #37.

The findings included:

1. For Resident #75, the facility staff failed to address drug regimen reviews completed by the

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pharmacist for the months of April 2022, June 2022, July 2022, and August 2022 each requesting a gradual dose reduction (GDR) review for the antidepressant medications Sertaline and Trazodone.

Resident #75's diagnosis list indicated diagnoses, which included, but not limited to Chronic Diastolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Paroxysmal Atrial Fibrillation, Major Depressive Disorder, and Generalized Anxiety Disorder.

The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 9/02/22 assigned the resident a brief interview for mental status (BIMS) summary score of 10 out of 15 indicating the resident was moderately cognitively impaired.

Upon review of Resident #75's clinical record on 10/13/22, surveyor was unable to locate drug regimen reviews completed by the pharmacist for the months of April 2022, June 2022, July 2022, and August 2022. On 10/13/22 at approximately 8:15 am, surveyor spoke with the director of nursing (DON) and requested the drug regimen reviews.

On 10/13/22 at 12:10 pm, licensed practical nurse (LPN) #3 provided surveyor with copies of Resident #75's drug regimen reviews for April 2022, June 2022, July 2022, and August 2022. The drug regimen reviews were not signed by the physician and there was no documentation indicating the drug regimen reviews were reviewed by the physician. LPN #3 stated they did not have physician signed pharmacy reviews for April 2022, and June through August 2022.

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F 756	Continued From page 3 LPN #3 stated the drug regimen reviews were received monthly from the pharmacy, given to the physician liaison who then distributed to the Unit Managers for review and then returned to the physician liaison who provided to the physician for review. LPN #3 stated for any resident followed by Dr. (name omitted) (geriatric psychiatry), drug regimen reviews were sent to them and there seemed to be an issue with getting the reviews back as sometimes they would return the reviews directly to the pharmacy. Resident #75's April 2022 drug regimen review stated in part " ...Please review the following orders for the possibility of a GDR: 1. Sertraline 50 mg qd (once a day) 2. Trazodone 25 mg HS (at bedtime) ..." Resident #75's June and July 2022 drug regimen reviews each stated in part " ...I apologize if this was already addressed but I could not find a response in the eChart or email ...Please review the following orders for the possibility of a GDR: 1. Sertraline 50 mg qd 2. Trazodone 25 mg HS ..." The August 2022 drug regimen review stated in part " ...Please ensure Dr. (name omitted) receives this review, as this is the third attempt for a GDR that I do not think Dr. (name omitted) has seen ...Please review the following orders for the possibility of a GDR: 1. Sertraline 50 mg qd 2. Trazodone 25 mg HS ..." Surveyor requested and received the facility policy entitled "Drug Regimen Review" which read in part: 3. When there are pharmacy recommendations due to the finding of the drug regimen review, a detailed recommendation will be promptly provided to the attending physician, designee or psychiatrist and director of nursing. A. All pharmacy reviews identifying specific	F 756		

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recommendations will require action to be taken in the form of a written response to the drug regimen review.

On 10/13/22 at 3:48 pm, the survey team met with the administrator, DON, assistant DON, and LPN #3 and discussed the concern of Resident #75's drug regimen reviews not being addressed by the facility.

No further information regarding this concern was presented to the survey team prior to the exit conference on 10/13/22.

2. For resident # 37, the facility staff failed to ensure that the drug regimen review for August 2022, was reviewed and the recommendation for a gradual dose reduction was addressed by the attending physician.

Resident #37's diagnosis list includes, but is not limited to the following: mood disorder with major depressive like episode, insomnia, type 2 diabetes mellitus, hemiplegia following cerebral infarction, dysphagia and aphasia.

The most recent quarterly minimum data set (MDS) with an assessment reference date of 08/01/2022, assigned the resident a BIMS (brief interview for mental status) summary score of 11 out of 15 in section C, cognitive patterns, indicating the resident was moderately cognitively impaired.

Upon review of resident #37's clinical record, surveyor was unable to locate the August 2022 drug regimen review completed by the pharmacist.

On 10/12/2022 at 6:25 pm, surveyor spoke with

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F 756	Continued From page 5 the Director of Nursing (DON), who stated the review had not been scanned into the medical record yet and she would have that done as soon as possible. On 10/13/2022 at 8:00 a.m., surveyor noted that the medical record had been updated with a form entitled, "Physician Recommendation From Pharmacist", dated 8/24/2022. The form indicated that the pharmacist had recommended a gradual dose reduction for trazodone (an antidepressant medication) 50 mg at hour of sleep for insomnia and depression. There was no indication on the form that a physician had seen the recommendation, the form was devoid of a physician's response or signature. On 10/13/22 at 12:10 pm, licensed practical nurse (LPN) #3 stated the drug regimen reviews were received monthly from the pharmacy, given to the physician liaison, who then distributed to the Unit Managers for review. Once reviewed by the unit manager, pharmacy reviews are then returned to the physician liaison, who provides them to the physician. LPN #3 stated for any resident followed by Dr. (name omitted) (geriatric psychiatry), drug regimen reviews were sent to them, and there seemed to be an issue with getting the reviews back, as sometimes they would return the reviews directly to the pharmacy. Surveyor requested and received the facility policy entitled "Drug Regimen Review" which read in part: 3. When there are pharmacy recommendations due to the finding of the drug regimen review, a detailed recommendation will be promptly provided to the attending physician, designee or psychiatrist and director of nursing. A. All pharmacy reviews identifying specific	F 756		

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F 756	Continued From page 6 recommendations will require action to be taken in the form of a written response to the drug regimen review. On 10/13/22 at 3:48 pm, the survey team met with the administrator, DON, assistant DON, and LPN #3 and discussed the concern of Resident #37's drug regimen review not being addressed by the facility. No further information regarding this concern was presented to the survey team prior to the exit conference.	F 756		
F 761 SS=E	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	F 761	**F 761 (12VAC 5-371-300 (B))** **Corrective Action(s):** The facility immediately removed the medications stored improperly for resident #27 and provided the resident with education surrounding medication administration and storage policies. The facility also removed and discarded the unlabeled insulin along with the improperly labeled bag. Lastly, the facility provided all employees with education surrounding medication administration and storage of medications. **Identification of Deficient Practices/Corrective Action(s):** The facility audited all other residents identified as being safe to self-administer medications to ensure their medications were being stored properly with no others identified as being out of compliance. The facility also performed a 100% cart audit and administration audit to ensure insulin were stored properly and medications weren't left unattended and were inaccessible. There were no other cases where medications were stored inappropriately. Additionally, the facility performed in-services with all staff surrounding proper storage of medications.	11/7/2022

	Systemic Change(s): The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's Unit Managers will perform audits weekly to ensure compliance with storage surrounding medication carts as well as those resident's who have been deemed safe to self-administer medications. **Monitoring:** The DON and ADON will be responsible for monitoring compliance. To assist with compliance monitoring, the DON and ADON, or designee, will review the monthly audits completed by the facility's Unit Managers. The DON/ADON will be responsible for implementing additional education, disciplinary action, and process changes to ensure compliance is maintained. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	

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F 761	Continued From page 7 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, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications/supplements were stored in a locked compartment in a resident room for 1 of 24 (Resident #27), failed to label and store medication appropriately on 1 of 4 wings (wing 1), failed to keep medications in direct line of sight until administered for 1 of 4 Residents during a medication pass (Resident #10), and failed to lock an unattended medication cart on 1 of 4 wings (wing 3). The findings include: 1. For Resident #27, the facility staff failed to store supplements in a locked compartment. Resident #27 had been approved to self-administer their supplements these were observed to be kept in an unlocked drawer in the residents room. Resident #27's diagnosis included, but were not limited to, quadriplegia and polyneuropathy. Section C (cognitive patterns) of Resident #27's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 07/22/22 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Resident #27's clinical record included a provider	F 761		

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order to keep the following supplements at bedside: coconut oil capsule (09/25/18), ginger root (07/31/19), super B-complex (07/31/19), turmeric (07/31/19), and vitamin D3 (07/31/19).

Resident #27's comprehensive care plan included the focus area keeps supplements per her choice, and as approved by MD at bedside, and completes self-administration. These include: Coconut Oil, Ginger Root, Super B Complex, Turmeric, and Vitamin D. Interventions included, but were not limited to, consult MD for discussion with patient should they be noncompliant with self-administration of these medications. Medications to be kept in a lock box in the patients room.

Resident #27's clinical record included a self-administration of medications assessment completed on 04/30/21 that was signed by the provider indicating the resident was granted approval for self-administration of medications.

10/12/22 3:40 p.m., the surveyor observed Resident #27 open the second drawer of a small dresser and remove the following supplements Vitamin C, Super B complex, Dong Quai, D3, Magnesium, Biotin, Coconut oil. Resident #27 left a container of Hemp cream in the drawer and stated this was used for pain. Resident #27 stated they were going to let the staff administer her medications, she may have had a lock box one time, but she turned it back in.

10/12/22 3:45 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) the issue regarding the supplements was discussed.

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10/13/22 the facility staff provided the survey team with a copy of a document titled, "Medication Storage" policy date 03/2016. This document read in part, "...A medicine cabinet, container or compartment shall be used for storage of medications prescribed for residents...Medication Storage...The storage area shall be locked..."

10/13/22 12:15 p.m., Licensed Practical Nurse (LPN) #1 stated they were returning the supplements to the pharmacy.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility nursing staff failed to label insulin with a Residents name and stored Novolog insulin in a bag labeled Lantus insulin.

10/13/22 12:10 p.m., checked medication cart wing 1 with Registered Nurse (RN) #1. This medication cart contained a clear baggy labeled with the name of Resident #87 and Lantus insulin. Inside this clear baggy was 3 insulin pens 2 Lantus and 1 Novolog. Only 1 insulin pen included a label with Resident #87's name and the type of insulin (Lantus).

Resident #87's clinical record included an order for Lantus insulin (04/12/22). The Novolog had been discontinued by the provider on 10/10/22. The clinical record included the diagnosis type 2 diabetes mellitus.

10/13/22 1:03 p.m., RN #1 reviewed Resident #87's clinical record and stated the Novolog

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insulin had been discontinued and they had discarded the unlabeled insulin pens.

10/13/22 the DON staff provided the survey team with a policy titled, "Medication Labeling." This policy read in part, "...All medications shall remain in the pharmacy issued container, with the legible prescription label or direction label attached..."

10/13/22 3:45 p.m., the Administrator, DON, ADON, and LPN #3 were made aware of the issue regarding labeling and storage of the insulin pens.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. The facility staff failed to lock an unattended medication cart and left a medication cup containing an Aspirin 81 mg tablet (nonsteroidal anti-inflammatory) and a Coreg 12.5 mg tablet (beta blocker used to treat heart failure and hypertension) unattended on the top of the medication cart.

On 10/12/22 at 9:12 am, during a medication pass and pour observation, licensed practical nurse (LPN) #4 began preparing medications for Resident #10. LPN #4 placed an Aspirin 81 mg tablet and a Coreg 12.5 mg tablet in a medication cup on the top of the medication cart located in the hallway outside of Resident #10's door. LPN #4 then stated they needed to obtain the resident's blood pressure and turned and walked away from the medication cart and down the hall out of the surveyor's sight leaving the medication cart unlocked and the cup containing Aspirin and Coreg on top of the medication cart unattended

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F 761	Continued From page 11 and out of their sight. Surveyor remained with the medication cart and LPN #4 returned to the cart at 9:13 am with a vital sign machine. LPN #4 then placed the medication cup containing Aspirin and Coreg in a drawer of the medication cart and entered Resident #10's room with the vital sign machine. LPN #4 did not lock the medication cart prior to entering the resident's room and the cart was out of their direct line of sight while obtaining the resident's vital signs. Surveyor requested and received the facility policy entitled "Administering Medications" which read in part: 9. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to the residents or others passing by. On 10/12/22 at 3:48 pm, the survey team met with the administrator, director of nursing, and assistant director of nursing and discussed the concern of LPN #4 leaving the medication cart unlocked and medications unattended on top of the medication cart. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/13/22.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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	495421	A. BUILDING _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 880	Continued From page 12 §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. 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,	F 880	**F 880 (12VAC 5-371-180)** **Corrective Action(s):** Upon learning of the encounter the survey team had with employee #4, the facility immediately provided the employee with education, instructed the employee to wash their hands and cleaned/disinfected all equipment being utilized by the employee. **Identification of Deficient Practices/Corrective Action(s):** The facility performed hand hygiene audits to include use of shared medication equipment and found no other cases of non-compliance. Additionally, the facility immediately initiated staff education surrounded the facility's infection control practices, polies, and procedures. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The Unit Managers will perform infection control audits no less than weekly to observe and monitor hand hygiene surrounding medication administration as well as use of shared medical equipment. **Monitoring:** The facility's Infection Preventionist will be responsible for monitoring compliance, reviewing weekly audits to ensure compliance as well as any trends that may exist. The Infection Preventionist will be responsible for implementing additional education, disciplinary action, and process changes to ensure compliance is maintained. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	11/7/2022

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F 880	Continued From page 13 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 (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 staff interview, facility document review, and during a medication pass and pour observation, the facility staff failed to maintain an infection prevention and control program to provide a safe, sanitary, environment and help prevent the development and transmission of communicable disease and infections on 1 of 4 facility wings, Wing #3. The findings included: During a medication pass and pour observation,	F 880		

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F 880	Continued From page 14 the facility staff failed to perform hand hygiene and failed to sanitize vital sign equipment between resident uses. On 10/12/22 at 8:55 am, during a medication pass and pour observation, surveyor observed licensed practical nurse (LPN) #4 obtain Resident #44's blood pressure and oxygen saturation utilizing a Dinamap vital sign machine. LPN #4 placed the blood pressure cuff on the resident's arm and the oxygen sensor on the resident's finger. LPN #4 failed to sanitize the blood pressure cuff or the oxygen finger sensor following use and immediately returned the Dinamap vital sign machine to the hall storage area. The vital sign machine included an attached compartment with a container of Super Sanicloth sanitizing wipes. LPN #4 also failed to perform hand hygiene prior to exiting Resident #44's room following obtaining vital signs and administering medications. Hand sanitizer was available in Resident #44's room beside the door and a sink was also available in the resident's room. LPN #4 immediately returned to the medication cart and began preparing medications for Resident #10 without performing hand hygiene. A bottle of hand sanitizer was available on top of the medication cart. While preparing Resident #10's medication, LPN #4 stopped and obtained a Dinamap vital sign machine, entered Resident #10's room and obtained a blood pressure, temperature, and oxygen saturation without performing hand hygiene. LPN #4 failed to sanitize the blood pressure cuff or oxygen finger sensor following use and returned the vital sign machine to the hall. The Dinamap vital sign machine included an attached compartment with	F 880		

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F 880	Continued From page 15	F 880		

a container of Super Sanicloth sanitizing wipes. LPN #4 also failed to perform hand hygiene prior to exiting Resident #10's room following obtaining vital signs and administering medications. Hand sanitizer was available in Resident #10's room beside the door and a sink was also available in the resident's room.

LPN #4 immediately returned to the medication cart and proceed to prepare medications for another resident without performing hand hygiene. A bottle of hand sanitizer was available on top of the medication cart.

On 10/12/22 at 9:43 am, surveyor asked LPN #4 when hand hygiene should be performed during medication passes and they stated they usually use hand sanitizer when coming out of a resident's room and wash hands after every couple of rooms.

Surveyor also asked LPN #4 how shared medical equipment was handled between resident use, they stated it was sanitized with wipes after every couple of residents.

Surveyor requested and received the facility policy entitled "Shared Medical Equipment (Tube Feeding Machines, IV Machines, EKG Machine, Bladder Scanner, Dinamaps, Temporal Thermometer)" which read in part:
7. For daily use of Dinamaps, clean after each resident use with approved germicidal cleaner (Oxovir). Wipe down the machine, all cords (cuff and pulse ox) and temporal thermometer and allow to dry for 1 minute before use on another resident.

On 10/12/22 at 3:48 pm, survey team met with

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F 880	Continued From page 16 the administrator, director of nursing, and assistant director of nursing and discussed of concern of LPN #4 failing to perform hand hygiene and sanitize shared medical equipment between resident uses. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/13/22.	F 880		