Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#5964**			**Date:** **January 11, 2023**
Facility Name: **Valley Vue**		**Survey Dates:** **December 20-27, 2023**	
Facility Address/City/State/Zip **108 Second Ave Armstrong, IA 50514**	**DC**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(2)a	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *a.* Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II) **DESCRIPTION:** Based on observations, clinical record review, resident representative interview, staff interviews, facility policy, and facility record review, the facility failed to ensure residents were free from significant medication errors for 2 of 2 residents reviewed (Resident #133 and #25). The significant medication errors resulted in hospitalizations. The facility failure resulted in an Immediate Jeopardy to the health, safety, and security of the residents. The facility also failed to ensure the right dose of a medication was administered for 1 of 6 residents reviewed for administration of medications, (Resident #13). The facility also failed to ensure documentation of narcotic medication was completed according to accepted standards of practice. The facility reported a total census of 31 residents.	**I**	**$7750.00 (Held in Suspension)**	**UPON RECEIPT**

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	Findings include: 1. Resident #133's Minimum Data Set (MDS) assessment dated 4/8/22 identified a Brief Interview for Mental Status (BIMS) score of 05, indicating moderate cognitive impairment. The MDS identified Resident #133 had signs and symptoms of delirium with inattention with behavior present and disorganized thinking. The MDS identified Resident #133 required extensive assistance of two persons with bed mobility, transfers and toilet use. Resident #133 required extensive assistance of two persons and a walker for ambulation. Resident #133's MDS included diagnoses of heart failure, coronary artery disease, hypertension, renal insufficiency, diabetes mellitus, Alzheimer's disease, and anxiety disorder. The resident had hospice services. A Progress Note dated 5/2/22 at 1:30 p.m. titled Incident Report- Medication event revealed Staff A, Licensed Practical Nurse (LPN) observed a fentanyl patch on Resident #133's right back shoulder. Staff A, LPN reviewed Resident #133's physician orders and identified she did not have a prescription for a fentanyl patch. Staff A, LPN removed the fentanyl patch from Resident #133's back and reported the incident to the Director of Nursing (DON). Staff A, LPN completed a nursing assessment on Resident #133. The nursing assessment revealed Resident #133 was very lethargic, difficult to arouse and unable to get out of bed. Vital signs documented in the Progress Notes were abnormal with a pulse of 121 beats per minute, respirations 10 breath per minute and pulse oximeter			

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	88% on room air. Staff A, LPN notified Resident #133's Physician, Responsible party and Hospice regarding the medication error and potential drug overdose. A Progress Note dated 5/2/22 at 2:15 p.m. revealed the facility received a physician order to start oxygen at 2 liters per nasal cannula and to titrate the oxygen to keep pulse oximetry above 90%. Vital signs documented at 2:15 p.m. revealed Resident 133's pulse was 107 beats per minute, respirations 12 breaths per minute and pulse oximetry 92% on 2.5 liters of oxygen per nasal cannula. A Progress Note dated 5/2/22 at 4:30 p.m. titled Transfer to Hospital Summary revealed Resident #133 transferred to the hospital for evaluation due to a medication error. A Hospice Visit Note Report dated 5/2/22 documented the facility reported a 75 mcg (microgram) fentanyl patch had been observed on Resident #133 without a physician order. The hospice note documented Resident #133's vitals were abnormal. The vital signs in the note revealed the following information: temperature 99.1 degrees Fahrenheit, pulse 94-114 beats per minute, respirations 9-10 per minute and blood pressure 115/75. The hospice note stated Resident 133's heart rate was irregularly irregular radially and apically. The hospice note documented Resident #133 had experienced bradypnea (slow respiration rate) at 9-10 breaths per minute. The hospice note stated Resident #133's respirations were even and unlabored with deep breaths every 5-7			

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	seconds. The hospice note stated the facility had reported Resident #133 was not able to take her medications due to lethargy. The hospice note documented Resident #133 was unresponsive to verbal or tactile stimulation and the family had made the decision to transfer Resident #133 to the hospital Emergency Department for an evaluation. The note further stated an ambulance service arrived at the facility around 4:30pm. A Hospital Discharge Summary printed 5/3/22 at 10:55 a.m. stated Resident #133's principal diagnosis was a drug adverse reaction. The hospital discharge summary stated Resident #133 was found to have an opiate reaction resulting in lethargy. The emergency room had contacted Poison control, who recommended Resident #133 be treated for an opiate overdose with intermittent Narcan due to her lethargy. According to the hospital discharge summary, Poison Control recommended Resident #133 be admitted to the hospital for observation to allow the fentanyl to be metabolized. The hospital discharge summary stated Resident #133 was admitted on 5/2/22 and discharged on 5/3/22. An unsigned Facility Investigation Report dated 5/3/22 stated Staff B, CMA on 5/1/22 at 11:15 a.m. opened the narcotic box and removed a fentanyl patch from the box without looking at whose box it was per the video camera footage. Staff B, CMA placed the patch on top of the medication cart and then proceeded to punch medications out of the medication cards. At 11:30 a.m. per the video camera footage, Resident			

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	#133 walked to the dining room with staff for the noon meal. At 11:35 a.m. Staff B, CMA went to the table to administer Resident #133's medications. After administering the medication, Staff B applied the patch to Resident #133's right side. The facility investigation reported the morning of 5/2/22 Staff H, CNA checked on Resident #133 multiple times and was unable to wake her up. At 1:00 p.m. on 5/2/22 Staff H, CNA and Staff I, CNA attempted to wake up Resident #133 to perform cares. Staff H, CNA and Staff I, CNA sat Resident #133 on the side of the bed and she vomited. The facility investigation reported Staff A, LPN came to Resident #133's room and performed a nursing assessment and then left the room to call hospice. Staff H, CNA and Staff I, CNA changed Resident #133's clothes and during that time noted a patch on Resident #133's right shoulder blade and identified it as a fentanyl patch. According to the facility investigation when Staff A, LPN returned to the room, Staff H, CNA and Staff I, CNA questioned Staff A, LPN on when Resident #133 started on a fentanyl patch. The investigation further reported that Staff A went to check Resident 133's orders and identified there was not an order. Staff A returned to Resident 133's room to remove the patch. During an interview on 12/20/22 at 11:30 a.m. Resident 133's daughter and Power of Attorney (POA) reported she had visited her mom (Resident #133) on 5/1/22. The POA reported her mom was very groggy and out of it during the visit. The POA stated the next afternoon she received a call from the head nurse at the facility that her mom had been in bed all morning.			

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	The POA reported the head nurse stated the aides went in to change her mom and noticed the wrong patch was on her. The POA stated that her mom was to have a lidocaine patch on and it was a fentanyl patch that the staff found on her. The POA stated the nurse reported she had removed the patch immediately. The POA reported that she came to the facility to meet with hospice and facility staff. The POA reported the hospice nurse suggested her mom go to the Emergency Room to get a shot to reverse the fentanyl. The POA reported her mom received two or three shots in the emergency but was not coming out of it. The POA reported the Emergency Room Doctor suggested her mom stay overnight for observation. The POA reported she talked to the Administrator the next day. The POA stated the Administrator reported the facility had looked into it, found out who did it and took care of the situation. During an interview on 12/20/22 at 2:30 p.m. the Director of Nursing (DON) reported the Administrator completed the full investigation regarding Resident #133's medication error. The DON reported she completed the action plan with the nurses. The DON reported Resident #133's lidocaine patches are not stored in the same place as a fentanyl patch. The DON reported fentanyl patches are kept in a locked drawer on the medication cart since they are a controlled substance. The DON reported Staff B, Certified Medication Aide (CMA) placed a fentanyl patch on Resident #133 instead of her lidocaine patch. The DON reported Staff B, CMA is not new at the facility and is an experienced CMA. The DON reported			

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	Staff B, CMA had administered Resident #133's lidocaine patches before. The DON reported the video footage showed very clearly of what happened. During an interview on 12/21/22 at 9:34 a.m. the Administrator reported the video footage is only available for 7 days. She stated there was no way to recover the footage. The Administrator stated the video cameras have been set up that way since they were installed. The Administrator stated when she completed the investigation, she watched the video footage and then had Staff B, CMA watch the video so she would know what she had done. The Administrator stated she wrote the investigation based on the video footage and the interviews with the staff. During an interview on 12/21/22 at 10:07 a.m. Staff B, CMA reported when she was getting Resident #133's medications prepared on the morning of 5/1/22, she recalled another staff member coming up to her to inform her another resident had requested his fentanyl patch be applied. Staff B, CMA stated she had the other resident on her mind when she went to get Resident #133's patch out of the medication cart and took the other resident's patch (fentanyl) by mistake. Staff B, CMA stated the fentanyl patch are kept in a locked drawer and Resident #133's lidocaine patches are kept in the drawer right below it. Staff B, CMA reported Resident #133's lethargy did increase due to the fentanyl patch. Staff B reported after the medication error occurred the facility suspended her for 2 1/2 days and she was not allowed to work on the floor as a CMA for over a month. Staff B reported she			

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	asked Administration to allow her to return to the floor as a CMA. Staff B, CMA does not recall meeting with a Corporate Nurse prior to returning to work as a CMA. Staff B, CMA reported she did not receive any additional education or training after the medication error occurred. Staff B reported she no longer administers or has access to narcotic medications. During an interview on 12/21/22 at 10:30 a.m. the Administrator reported that both the Corporate Office and herself made the decision for Staff B to resume the CMA role in June 2022. The Administrator reported the facility had put safeguards/interventions in place to prevent another narcotic error from occurring. The Administrator reported there was no education or training provided to Staff B, CMA after the medication error on 5/2/22 occurred. On 12/21/2022 at 12:00 p.m. the Administrator provided Medication Administration Skills Checklists for Staff B, CMA. The skills checklists were completed in February 2022 (prior to the medication error) from the Assisted Living facility. The Administrator reported Staff B, CMA had worked in both Assisted Living and in the Nursing Home as a CMA. During an interview on 12/21/2022 at 3:00 pm a Law Enforcement Officer reported he went to the nursing home to assist with the ambulance call after hearing of a drug overdose at the facility. The Law Enforcement Officer reported when he arrived at the facility the staff reported Resident #133 had been administered a fentanyl patch that wasn't prescribed to her. He stated			

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	the resident was lethargic and incoherent. During an interview on 12/22/2022 at 11:00 a.m. the Video Service Company reported they installed the video cameras at the facility. The service company reported they set up the cameras per the owner's direction. They verified the camera footage is only available for 7 days then overwritten and there is no way to retrieve the footage from May 2022. A facility policy titled Medication Error and Medication Discrepancy revised 7/05 stated the preparation and administration of drugs and biologicals will be done in accordance with physician's order, manufacturer's specifications, and accepted professional standards and principals. The facility has systems designed to minimize medication error and that require investigation and corrective action when errors are discovered to prevent recurrence. The policy further states a medication error is defined as the preparation or administration of a drug or biological not in accordance with a physician orders, a manufacturer's specification or accepted professional standards. The policy stated a significant medication error is one which, in the charge nurse's professional judgment, causes the resident discomfort or jeopardizes the resident's health or safety, based on the resident condition, the drug category of medication involved and the frequency or duration of the error at the time of the discovery. 2. An MDS dated 11/30/22 for Resident #25, documented a BIMS of 15 which indicated no cognitive			

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	impairment. The MDS revealed the resident had clear speech, ability to understand others and make herself understood. Medical Diagnoses listed on the MDS were acute respiratory failure with hypoxia (low oxygen in the blood), hepatic failure, chronic kidney disease stage 4, type two diabetes mellitus with insulin use, non-alcoholic cirrhosis of the liver, morbid obesity, congestive heart failure, diffuse traumatic brain injury, mild cognitive impairment, anxiety and obstructive sleep apnea. Record review of Progress Notes indicated on 1/21/22 at 7:52 PM, Staff F, Registered Nurse (RN) held the resident's Seroquel due to not being alert. At 7:55 PM Staff F documented that she was alerted by staff the resident was acting "off" and that she was normally alert and oriented. Staff F assessed resident and reported respirations of 6 breaths per minute. She noted the resident was not alert, she was sweating, and her eyes were rolling to the back of her head. Staff F documented that she was able to rouse the resident who could state her first name but then fell right back to sleep. Documentation indicated Staff F was made aware the resident had received hydromorphone prior to her coming to work and she became concerned that resident had possibly received an incorrect dose of medication. Staff F called the on-call provider and told them she felt the resident had been given an incorrect dose of hydromorphone. Orders were received to administer Narcan as many times as needed until the resident became alert, and if she did not become alert to call 911. Documentation showed the resident received 0.4 milligrams (mg) of Narcan intramuscularly			

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	at 8:19 PM and 8:15 PM and that both doses were ineffective. At 8:45 PM documentation revealed the resident was transferred by ambulance to the hospital. Spouse was notified via telephone at 8:50 PM of the situation. Documentation in a Progress Note on 1/22/22 at 1:13 AM showed Staff F called the hospital and was informed they would be keeping resident due to low blood pressure and she was now needing oxygen. The Progress Note also indicated the Dr. stated that her ammonia level was critically low and that could also be a possibility of her confusion. Documentation on 1/24/22 at 10:35 AM showed the resident was being discharged back to facility via facility van. Review of the Hospital Discharge Summary signed by the Dr. on 1/24/22, showed a principal diagnosis of overdose drug, initial. Secondary diagnoses of hepatic encephalopathy without coma, encephalopathy metabolic, mild neurocognitive disorder secondary to traumatic brain injury, hypertensive heart with heart failure and chronic kidney disease, cirrhosis nonalcoholic, hyperammonemia, and diabetes type 2 were also listed. Details of hospital stay revealed reason for admission was change in mental status, overdose drug initial, and hepatic encephalopathy without coma. Physician documentation of history of present illness indicated that resident unintentionally received 10 times her dose of Dilaudid. It stated the nursing home reported the resident was given 5 mg of Dilaudid instead of 0.5 mg that she was prescribed. Documentation also revealed the resident received 2 doses of Narcan in the ambulance with good results.			

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	This summary also indicated that the liquid medication was poured into a cup rather than a syringe and so it was unclear exactly how much she received. Further documentation from the discharge summary indicated that the resident remained somnolent (drowsy) and that her labs were mostly unremarkable except for an elevated ammonia level of 83. She was admitted for observation on 1/21/22 and discharged back to facility on 1/24/22. Review of the Investigative Report from the facility revealed that Staff D, Certified Medication Assistant (CMA) went to administer the resident's Dilaudid (hydromorphone) medication and realized there was no syringe in the medication box to administer it with, so she poured the medication into a liquid medication cup. When Staff F came to work she noticed that the resident was acting "off". Documentation noted that Staff F had not yet met the resident because they had just been admitted to the facility 3 days prior and she did not know what her baseline was. Staff F conducted an assessment of vital signs and all were normal with the exception of respirations which were 6. After the 2 doses of Narcan had been administered per on-call orders, respirations increased to 10 and the resident became slightly more alert. Staff F then called 911 to report a potential drug overdose. At 8:45 PM the resident left the facility by ambulance to the Emergency Department. At 1:13 AM on 1/22/22 Staff F spoke with the emergency department and was told "per Dr.", residents' ammonia level was critically high and that could also have been a possibility of her confusion. Further documentation of the investigative			

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	report showed that Staff I updated the pharmacy regarding the incident and explained to them that nurses/CMA's would no longer be able to give liquid controlled medications without the proper syringe. Pharmacy voiced understanding and sent extra syringes for liquid controlled medication administration to be housed in the medication room. Nurses and CMAs were all educated on syringe use. Documentation was also noted that Administration investigated Staff D following the incident. Staff D was asked to show administration, in a liquid med cup, with water, what the amount of Dilaudid looked like when she administered it. Administration put 0.5ml of water in the liquid med cup via a syringe and Staff D stated that was more of what it looked like. Administration then filled the cup up to 5ml with water and Staff D stated, no, it wasn't that much. This investigative report was not dated. Along with the investigative report, a notice dated 1/24/22 was written by Staff I that any controlled liquid medications were only to be given with a medication syringe and not med cup. Medication syringes were ordered from the pharmacy located on a shelf in the medication room and unopened syringes were to be kept for future use. Review of the Medication Utilization C2 log revealed that on 1/20/22, 30 milliliters (mL)of Hydromorphone (Dilaudid) was signed in to the facility as having been being received by Staff K. On the first medication administration line, Staff K wrote 1/20/22 at 10:30 PM 0.5ml given, with an amount of remaining 29.5mls, and 0 wasted. There was noted to be a single, non-initialized line drawn in this entry. The following line is			

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	dated 1/21/22 at 6:00 AM, 0 mls given, signature of Staff K, amount remaining 30mL, and 0 wasted. The third line was shown to have a date of 1/21/22 at 1:00 PM, 0 mls given, initials that were unreadable, amount remaining 30mls, and 0 wasted. Both lines 2 and 3 are noted to have Staff E's initials under "checked by". On line 4, 1/21/22 at 5:10 PM, documented is 0.5ml given, Staff D initials, amount remaining 29.5mls, 0 wasted and no initials in the checked by box. On the 5th line dated 1/22/22 at 6:00 AM, 0 mls given, unreadable initial, amount remaining 25 mls, 0 wasted and unreadable initials in the checked by box. The log revealed the medication was discontinued 1/24/22, with 25 ml remaining, disposed of on 1/24/22, initialed by Staff E and signed by the Administrator. Interview with Staff D on 12/21/22 at 11:28 AM, revealed she came into work on the evening of 1/21/22 and was asked to give Resident #25 their medication. She stated she asked the nurse Staff E, LPN, what she needed to know about the resident and Staff E told her that she didn't know anything about the resident and to just give her the medication. She stated another nurse (unsure of what her name was) was working as an aide that night and called her to the resident's room and started yelling at her. She stated that she showed her what she gave and continued to be yelled at. She stated she texted the DON right away to let her know what was going on and that the following day, the Administrator spoke with her and said that they would look into it. Staff D reported she has been a med aide since the 1990's. She stated since the incident CMA's are not allowed to administer			

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	narcotics She stated she was not suspended nor did she receive any extra training or education. Interview with Administrator on 12/22/22 at 11:45 AM revealed that Staff D was not suspended because there was never a definite answer or proof that the resident received an overdose. Interview with Staff F on 12/22/22 at 11:44 AM revealed that 1/21/22 was the first time she had met Resident #25. She stated the resident just didn't look right. She admitted she did not know what her baseline was, but she felt like something was wrong. Staff F could not recall who gave the medication but that it was someone before her shift and she thought they had already left. She stated that she called the on-call provider and got orders for Narcan and to send to ED if needed. She stated that she remembered the resident has sort of liver and ammonia issues. Staff F stated that she left the facility sometime in February 2022 for a different job. Several attempts were made on 12/21/22 and 12/22/22 to contact both ED physicians regarding their comments documented regarding this resident's hospitalization and potential overdose. No calls were returned. 3. Resident #13's Minimum Data Set (MDS) dated 11/14/22 assessment identified a BIMS score of 10, indicating moderate cognitive impairment. The MDS identified Resident #13 was independent with bed			

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Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#5964**				**Date:** **January 11, 2023**
Facility Name: **Valley Vue**		**Survey Dates:** **December 20-27, 2023**		
Facility Address/City/State/Zip **108 Second Ave Armstrong, IA 50514**	**DC**			

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	mobility, transfers, toileting and ambulation using a walker. Resident #13's MDS included diagnosis of hypertension, hypercholesterolemia, gastro-esophageal reflux disease without esophagitis, and anemia. A Physician Order dated 5/17/22 directed staff to give famotidine 20 mg (milligrams) 0.5 tablet by mouth one time a day for gastroesophageal reflux disease without esophagitis. Review of Resident #13's Electronic Medication Record (EMAR) for December 2022 documented daily administration of famotidine 20 mg 0.5 tablet. On 12/21/2022 at 8:00 a.m. observed Staff B, CMA administer famotidine 20 mg one tablet by mouth to Resident #13 at the dining room table. During an interview on 12/21/2022 at 10:00 a.m. with Staff B, CMA verified she gave a whole tab of famotidine to Resident #13 instead of a half of a tablet as directed by the Physician Order. Staff B, CMA stated she usually cuts the famotidine tablet in half before administering it and she did not this morning. A facility policy titled Medication Error and Medication Discrepancy revised 7/05 stated the preparation and administration of drugs and biologicals will be done in accordance with physician's order, manufacturer's specifications, and accepted professional standards and principals. The facility has systems designed to minimize medication error and that require			

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	investigation and corrective action when errors are discovered to prevent recurrence. The policy further states a medication error is defined as the preparation or administration of a drug or biological not in accordance with a physician orders, a manufacturer's specification or accepted professional standards. During an interview on 12/21/22 at 10:30 a.m. the Administrator reported she was aware of the medication error that occurred the morning of 12/21/22 with Staff B, CMA. The Administrator stated Staff B, CMA came to her right away to report it. 4. The Medication Utilization C3-5 log that contained entries from 12/15/22 to 12/21/22 revealed the following: a. Strikethrough lines through the number of tablets remaining for 5 entries from 12/18/22 at 6:00 PM to 12/19/22 at 2:00 PM. 1 of the 5 entries contained a date that was not legible. 1. The entry on 12/18/22 at 6:00 PM had the amount remaining (85) struck through and 84 written next to it. 2. The entry on 12/18/22 had a time that was not legible with the amount remaining (84) struck through and 83 written next to it. 3. The next entry line had a date that contained numbers that were not legible. The time was 6:00 AM. The amount remaining (84) had 83 written next to it. 4. The entry on 12/19/22 at 8:00 AM had the amount remaining (83) struck through and 82 written next to it.			

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	5. The entry on 12/19/22 at 2:00 PM had the amount remaining struck through (83) with 82 written next to it. b. 1 strikethrough line for an entry on 12/19/22 at 3:10 PM. c. A line drawn from an entry written on the log below the entry that was completely struck through up to the space on the log that contained entries on 12/18/22 at 7:20 AM and on 12/18/22 at 6:00 PM. An arrow was drawn at this point in between log entries. d. 4 different sets of initials were in the signature of nurse and checked by columns from 12/18/22 at 6:00 PM and 12/19/22 at 2:00 PM. The Medication Utilization C2 log with dates from 12/5/22 at 10:00 PM to 12/21/22 at 6:00 AM contained non legible and extraneous markings as follows: a. A number superimposed on an entry at 6:00 AM with an amount remaining entry as 30. b. An entry on 12/07/22 at 8:00 PM that contained writing superimposed on an amount wasted. c. An entry on 12/18/22 at 8:00 PM with unidentifiable writing next to an amount remaining of 19. The Individual Resident's Controlled Substance Record with entries from 12/10/22 at 10:00 AM to 12/21/22 at 6:00 AM contained non legible and extraneous markings as follows: a. An entry with a non legible date on 6:00 AM with an amount on hand listed as 38. b. An entry on 12/12/22 with writing superimposed for the time and amount remaining.			

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	c. An entry on 12/14/22 with a time that is non legible and writing superimposed for the amount remaining. This entry had the amount on hand listed as 32 along with the word 2 listed as the amount given. d. An entry on 12/15/22 with a time that is non legible with 26 listed in both the amount on hand and the amount remaining columns. The Controlled Medications policy revised 06/06/16 directed that all CIII-CV (routine and prn [as needed]) If a variance in the amount of medication in the bottle/container and the amount recorded as remaining is noted, an investigation will be initiated by the Nursing Supervisor/Charge Nurse. If the discrepancy cannot be found/determined, notify the DON [Director of Nursing] and Administrator for further investigation. The investigation may be recorded on plain paper or on the Medication Discrepancy Report (MP5427). Contact the CQI [Continuous Quality Improvement] Resource Center for assistance with investigation. In an interview on 12/21/22 at 10:28 AM the Director of Nursing (DON) and Staff C, corporate nurse consultant, agreed that best practice in nursing documentation is to place a strikethrough line through charting entered in error and to follow facility policy to add information to include that the charting was made in error, date, time, and initials of the nurse. The facility was notified of the Immediate Jeopardy and given the IJ template on 12/21/22 at 12:55 PM. The			

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	facility provided education to staff on medication administration by completing skills checklists and Relias (learning program) training with learning objectives for medication administration. The Immediate Jeopardy was corrected on 12/21/2022. At the time of exit the scope and severity was lowered to a D after verification of the facility's implementation of the correction plan. **FACILITY RESPONSE:**			

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