

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/08/13</p> <p>Facility Number: 012534 Provider Number: 155792 AIM Number: 201028420</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Countryside Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>resident sleeping rooms. The facility has a capacity of 171 and had a census of 144 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide the one hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 22 residents, staff and visitors in the 500 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the annular space surrounding a</p>	K010025	<p>K025 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The annular space surrounding a one inch diameter pipe in the ceiling in the Mechanical Room inside 500 Hall Laundry Service Room was immediately filled with fire rated caulking. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All of utility and service rooms were inspected to ensure there were no other areas out of compliance What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; all vendors will be mandated to ensure that any work requiring cutting or altering covered space will notify the Maintenance Director.Any areas that have been altered will be</p>	12/08/2013	

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	<p>one inch in diameter pipe in the ceiling above a natural gas fired furnace in the Mechanical room inside the 500 Hall Laundry Services Room was not filled with a material capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device designed for the specific purpose. Two layers of 5/8th inch drywall was observed installed as the ceiling of the aforementioned natural gas fired furnace room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the ceiling of the Mechanical room inside the 500 Hall Laundry Services room failed to provide a one hour fire resistance rating of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>required to be filled by the contractor with the appropriate fire rated caulking.If the contractor cannot fill these areas they will inform the Maintenance Director so the appropriate action is taken. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. The Maintenance Director will keep a log of all vendors requiring work to be done in the ceilings of the facilities.This log will reflect any intrusions into the ceiling and assurance that the area has been remedied to meet standard compliance. Corrections will be completed by December 8, 2013.</p>		

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K010029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 17 of 20 doors serving hazardous areas such as fuel fired heater rooms, soiled linen and trash collection rooms and storage rooms greater than fifty square feet in size used to store combustible materials each have a 3/4 hour fire protection rating. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the following areas each had a natural gas fired furnace in the room and the entry room door had a 20 minute fire resistance rating label affixed to the door:</p> <p>a. Corridor door to the Mechanical room by the Dietary Storage Room .</p> <p>b. Corridor door to the Mechanical room by the Recreation Director's Office.</p> <p>c. Corridor door to the Mechanical room by the New Energy Wellness room near the main entrance.</p>	K010029	K029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All 17 doors identified to have a 20 minute fire rating on then will be replaced with doors having a ¾ hour fire rating. These doors have been ordered and will be replaced as soon as possible. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all other areas of the building were inspected by both the Life Safety Surveyor and Maintenance Director. All other doors were found to be in compliance what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Any door changes having to be made in the future will meet the required guidelines in regard to fire rating. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the	12/08/2013			

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	<p>d. Mechanical room in the 100 Hall Lounge.</p> <p>e. Corridor door to the Mechanical room by the Refreshment Pantry</p> <p>f. Corridor door to the 100 Hall Laundry Services room.</p> <p>g. Mechanical room inside the 100 Hall Laundry Services room.</p> <p>h. Corridor door to the 200 Hall Laundry Services room.</p> <p>i. Each of two Mechanical rooms inside the 200 Hall Laundry Services room.</p> <p>j. Corridor door to the 300 Hall Laundry Services room.</p> <p>k. Mechanical room inside the 300 Hall Laundry Services room.</p> <p>l. Corridor door to the 400 Hall Laundry Services room.</p> <p>m. Mechanical room inside the 400 Hall Laundry Services room.</p> <p>n. Corridor door to the 500 Hall Laundry Services room.</p> <p>o. Mechanical room inside the 500 Hall Laundry Services room.</p> <p>In addition, the Dietary Storage Room in the 400 Hall was used to store combustible boxes and supplies, measured 77 square feet in total area and the entry room door had a 20 minute fire resistance rating label affixed to the door. Each of the aforementioned laundry service's rooms were observed to store two or more 32 gallon mobile carts for soiled linen and trash. Based on</p>		<p>systemic changes will be completed. These doors will remain permanent. Therefore, the building will remain in compliance. Corrections will be completed by December 8, 2013.</p>				

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	<p>interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned room entry doors had a 20 minute fire resistance rating label affixed to the door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 20 hazardous areas such as fuel fired heater rooms were enclosed with a one hour fire rated barrier. This deficient practice could affect 22 residents, staff and visitors in the 500 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the annular space surrounding a one inch in diameter pipe in the ceiling above a natural gas fired furnace in the Mechanical room inside the 500 Hall Laundry Services Room was not firestopped. Two layers of 5/8th inch drywall was observed installed as the ceiling of the aforementioned natural gas fired furnace room with the aforementioned opening exposing the attic. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned</p>				

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	opening in the ceiling of the Mechanical room inside the 500 Hall Laundry Services room failed to enclose the area with a one hour fire barrier.  3.1-19(b)				

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 2 of 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided an irreversible</p>	K010038	<p>K038 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The two doors identified now have signs adjacent to the release device that are durable, readily visible and in letters not less than 1 inch high and not less than 1/8 inch in stroke width on contrasting background that reads: Push until alarm sounds door can be opened in 15 seconds. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all other doors were evaluated by Life Safety Surveyor and found to be in compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; these signs will remain permanently affixed on the doors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed All doors were surveyed and found to be in compliance. . Corrections will be completed by December 8, 2013.</p>	12/08/2013

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	<p>process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch (2.5 cm) high and not less than 1/8th inch (0.3 cm) in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 48 residents, staff or visitors trying to exit the facility from the 100 Hall and the 300 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the 100 Hall and the 300 Hall</p>						

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	<p>exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted at each exit. In addition, each of the aforementioned exit doors opened after the application of force for 15 seconds but each exit door was not equipped with signage stating the door could be opened after pushing on the door for 15 seconds. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned facility exits did not have the code posted and were each not equipped with signage stating the door could be opened after pushing on the door for 15 seconds. Based on interview during the exit conference at 4:15 p.m., the Administrator stated facility residents who have a clinical diagnosis requiring specialized security measures are housed in the 200 Hall and acknowledged the 100 Hall and 300 Hall exit doors did not have the code posted and were each not equipped with signage stating the door could be opened after pushing on the door for 15 seconds.</p> <p>3.1-19(b)</p>			

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K010052 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to install 2 of 211 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 5 staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the smoke detector on the ceiling in the kitchen receiving area corridor nearest the kitchen door and the smoke detector on the ceiling in the kitchen storage room were each located two feet from an air supply vent. Based on interview at the time of the</p>	K010052	<p>K052 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the smoke detectors identified in the kitchen area were relocated greater than three feet from the identified air handlers. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; these smoke detectors are permanently affixed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; all smoke detectors were surveyed and found to be in compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed the smoke detectors were moved immediately. Corrections will be completed by December 8, 2013.</p>	12/08/2013			

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	<p>observations, the Maintenance Director acknowledged each of the aforementioned smoke detectors were installed on the ceiling less than three feet from an air supply vent.</p> <p>3.1-19(b)</p>				

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 2 of 3 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any residents, staff and visitors using the 400 Hall Recreation Room exit or the 100 Hall Therapy Gym exit.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the following was noted: a. the exterior canopy at the 400 Hall</p>	K010056	K056 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the facility will install sprinklers under the two areas identified, the two canopies exceeding four feet located between the 400 hall recreation room exit and the 100 hall therapy gym exit. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all other areas in the facility were surveyed and are in compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; the sprinklers will be installed to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will	12/08/2013			

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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123		
(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	
	<p>Recreation Room exit was "V" shaped and extended ten feet from the building, was of wood and vinyl construction and was not provided with automatic sprinklers.</p> <p>b. the exterior canopy at the 100 Hall Therapy Gym door to the outside of the building was "V" shaped and extended eight feet from the building, was of wood and vinyl construction and was not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned canopies extended more than four feet from the building, was of combustible construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. These sprinklers will be permanently affixed therefore ensuring continued compliance. Corrections will be completed by December 8, 2013.</p>		

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K010064 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to inspect 1 of 16 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect four residents, staff and visitors in the Salon.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, the inspection tag affixed to the fire extinguisher located in the Salon lacked documentation of a monthly inspection for September and October of</p>	K010064	<p>K064 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The fire extinguisher identified in the salon was immediately inspected and tagged How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all of fire extinguishers were found to be in compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; all fire extinguishers will be inspected monthly and the tags will be dated and initialed by the Maintenance Director. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Corrections will be completed by December 8, 2013.</p>	12/08/2013			

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	<p>2013. Based on interview at the time of observation, the Maintenance Director stated additional fire extinguisher monthly check documentation was not available for review and acknowledged the aforementioned fire extinguisher lacked documentation of a monthly inspection for September and October of 2013.</p> <p>3.1-19(b)</p>				

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K010075 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 18.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 4 Bathing Rooms. This deficient practice could affect 22 residents, staff and visitors in the 400 Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:30 p.m. to 4:00 p.m. on 11/08/13, a 12 bushel (111.6 gallons) mobile soiled linen cart which contained soiled linen was unattended and stored in the 400 Hall Bathing Room. The corridor entry door to the 400 Hall Bathing Room had an affixed label stating the fire resistance rating of the door was 20 minutes. Based on interview at the time of observation, the Maintenance Director</p>	K010075	<p>K075 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; the twelve bushel mobile soiled linen cart was immediately removed from the shower room. Staff was in serviced on the restrictions of having such carts in the shower room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Signs were posted in the shower room reminding the staff that the carts are not to remain per regulation. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Shower rooms will be checked daily so that the carts are not left in the shower rooms How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>	12/08/2013

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	acknowledged the 12 bushel mobile soiled linen cart had a capacity of more than 32 gallons, was unattended and was being stored within a 64 square feet area not protected as a hazardous area.  3.1-19(b)		into place; and by what date the systemic changes will be completed. Corrections will be completed by December 8, 2013.		