

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2014
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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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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: 11/05/14</p> <p>Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Seymour Crossing 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 19, Existing 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility</p>	K010000	<p>The creation and submission of this plan of correction does not constitutes an admission by this provider of any conclusion set for set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and that facility be approve for Paper Compliance.</p>	

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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K010018 SS=E	<p>has a capacity of 115 and had a census of 93 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had two detached wooden storage sheds and a detached thirteen hundred square foot residential home used for storage which were not sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/14/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>						

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 18 resident room corridor doors on the 900 Hall would resist the passage of smoke with no impediment to closing the doors. This deficient practice affects 6 residents who reside in resident room numbers 907, 917, and 922.</p> <p>Findings include:</p> <p>Based on observations on 11/05/14 during a tour of the 900 Hall from 11:15 a.m. to 12:20 p.m. with the maintenance supervisor, the room doors to resident room 907, 917 and 922 each had between a one inch and two inch gap along the top and latching sides of the doors. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p>	K010018	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1) Maintenance will adjust the doors and replace the insulation to assure the doors will be sealed from smoke by 11/28/14. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. Maintenance will adjust the doors and replace the insulation to assure the doors will be sealed from smoke by 11/28/14. Other areas were inspected and no other areas were identified to have this problem. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance will check monthly x 6 months and then quarterly thereafter. 4) 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 in place. This will be monitored through quarterly inspections and the Environmental CQI conducted monthly for 6 months and then quarterly. Any issues identified during the quarterly inspections or monthly Environment CQI will be</p>	12/03/2014	

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 9 corridors and 1 of 135 room walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable 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 affects 27 residents who reside on the B Wing.</p>	K010025	<p>addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be addressed.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Maintenance has fire caulked all penetrations on 11/20/14. Maintenance has closed the open hole in B-wing medication room on 11/21/14. Fire rated caulk was installed to all areas of concern by the maintenance director on 11/20/14. 2) 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 residents have the potential to be affected by the alleged deficient practice. Fire rated caulk was installed to all areas</p>	12/03/2014	

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K010027 SS=E	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 11/05/14 from 9:45 a.m. to 1:50 p.m., the following locations had wall penetrations not firestopped;</p> <p>1. The Service Hall corridor outside the boiler room two, one half inch penetrations from electrical conduit with no fire stopping material used to seal the penetrations.</p> <p>2. The B Wing medicine room wall under the sink had a four foot by three foot area of drywall missing. The Service Hall corridor penetration not fire stopped and the B Wing medicine room wall missing drywall was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the</p>		<p>of concern by the Maintenance Director on 11/20/2014 and now we have no gapping issues. Other areas were inspected and no other areas were identified as having gapping issues. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all areas having gaps that need fire rated caulk are corrected. 4) 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 in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that all gaps are corrected. Any issues identified during the quarterly inspections or monthly CQI will be addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be address.</p>				

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	<p>door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 34 residents who reside on the B Wing.</p> <p>Findings include:</p> <p>Based on observation on 11/05/14 at 1:50 p.m. with the maintenance supervisor, the B Wing East set of smoke barrier doors had a one inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p>	K010027	<p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The smoke barrier doors at the B-Wing entrance were adjusted to ensure no gaps for smoke to penetrate. The adjustment was accomplished by the Maintenance Director on 11/26/2014. 2) 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 residents have the potential to be affected by the alleged deficient practice. The smoke barrier doors at the B-Wing entrance were adjusted to ensure no gaps for smoke to penetrate and now we have no gapping issues at this location. Other areas were inspected and no other areas were identified as having gapping issues. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all areas having gaps that need adjustment in the smoke barrier doors does not recur. 4) How the</p>	12/03/2014

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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. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 exit accesses had a clear and unobstructed exit width of at least 4 feet (48 inches). This deficient practice could affect any residents who would use the Service Hall exit during an evacuation.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance supervisor on 11/05/14 at 12:20 p.m., the Service Hall exit paved surface had a smoking location with six</p>	K010038	<p>corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that all gaps are corrected. Any issues identified during the quarterly inspections or monthly Environment CQI will be addressed timely by the Maintenance Director and/or designee. This will be review by the Quality Assurance Committee and action plans developed for any areas that needs to be address.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Maintenance moved all furniture and cigarette receptacles providing a clear 4 foot wide path leading from the exit of the building to the street. This was accomplished by the Maintenance Director on 11/21/2014. The Maintenance Director will now clearly mark the 4 foot path with lawn paint to be completed by 11/28/2014. 2) How other residents having the potential to be</p>	12/03/2014

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K010062 SS=E	<p>chairs and two smokers' oasis ashtrays obstructing access to the paved sidewalk surface leading to the street. The Service Hall exit obstructions were verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview,</p>	K010062	<p>affected by the same deficient practice will be identified and what corrective actions(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. 4 foot clear pathway leading from exit of building to the street is now evident as completed by Maintenance Director on 11/21/2014. 3) What measures will be put into place or systemic changes will be made to ensure that the deficient practice does not recur. The 4 foot pathway will be checked daily by housekeeping staff to assure clearance continues. 4) How the corrective action(s) will be monitored to ensure that deficient practice will not recur. i.e., what quality assurance program will be put in place. This will be monitored through daily inspections by housekeeping staff and any issues identified will be addressed timely by the Maintenance and/or housekeeping supervisor. This will be reviewed by the Quality Assurance Committee and action plans developed for any areas that need to be address.</p>	12/03/2014			

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	<p>the facility failed to replace 4 of over 300 sprinklers in the facility covered in paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 68 residents who use the main dining room, located adjacent to the kitchen and 20 residents who reside on the C Wing and would use the C Wing lounge.</p> <p>Findings include:</p> <p>Based on observations on 11/05/14 during a tour of the facility from 9:45 a.m. to 2:25 p.m. with the maintenance supervisor, the kitchen two sprinklers above the food preparation table, the laundry sprinkler by the clean laundry door, and the C Wing lounge sprinkler were completely covered in white paint. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p>		<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All affected sprinklers will be replaced by Dalmation. A representative from Dalmation came to Seymour Crossing 11/25/2014 and measured and took count of sprinklers needing to be replaced and we are awaiting confirmation of completion date. Gaps around the escution plate of sprinkler heads have been fire caulked by the Maintenance Director to ensure no smoke penetrations completed on 11/21/2014. 2) 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 residents have the potential to be affected by the alleged deficient practice. All affected sprinklers will be replaced by Dalmation. We are currently awaiting confirmation of completion date. 3) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Routine rounds will be conducted by the Maintenance Director or/designee to ensure that all sprinklers pass inspection and the escution plates are properly fire caulked to ensure no smoke penetrations. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what</p>		

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K010066 SS=F	<p>2. Based on observation and interview, the facility failed to ensure 4 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 37 residents who reside on the A Wing and use the A Wing shower room.</p> <p>Findings include:</p> <p>Based on observation on 11/05/14 at 1:00 p.m. with the maintenance supervisor, the A Wing shower room first shower stall sprinkler, the second shower stall two sprinklers and the sprinkler by the sink each had between a one half inch and one inch gap where the escutcheons were not tight fitting to the ceiling. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international</p>		<p>quality assurance program will be put in place. This will be monitored through quarterly inspections and the environment CQI conducted monthly for 6 months to ensure that sprinklers affected are corrected. Any issues identified during the quarterly inspections or monthly Environmental CQI will be addressed timely by the Maintenance Director or/designee. This will be review by the Quality Assurance Committee and action plans developed for any area that needs to be address.</p>				

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	<p>symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 area where smoking was permitted used the metal self closing containers for discarded smoking material. This deficient practice could affect all residents if a fire occurred at the outside location near the emergency generator room.</p> <p>Findings include:</p> <p>Based on observation at 10:45 a.m. with the maintenance supervisor, the outside Service Hall smoking location had thirty discarded cigarette butts mixed with leaves on the ground surface near the emergency generator room. Furthermore, the smoking location was eighty feet from the emergency generator room and the facility had two metal containers with self closing lids for discarded smoking material. This was verified by the</p>	K010066	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director and Houskeeping Supervisor removed and discarded all cigarette butts, trash, and leaves on 11/21/2014.</p> <p>2) 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 residents have the potential to be affected by the alleged deficient practice. Outside smoking area will be kept free of cigarette butts and trash. 3) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. Outside smoking area will be checked daily by housekeeping staff and any issues identified during the inspections will be addressed timely by the Maintenance Director or the</p>	12/03/2014			

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K010067 SS=A	<p>maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure 2 of 2 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully</p>	K010067	<p>Housekeeping Supervisor/Designee.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice will recur. i.e., what quality assurance program will be put in place. This will be monitored by housekeeping staff daily and any issues identified during the inspections will be address timely by the Maintenance Director or/designee. This will be review by the Quality Assurance Committee and action plans developed for any areas that needs to be address.</p> <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Van Guard was called to come to Seymour Crossing to inspect fire dampers. Van Guard inspected the entire building and reports this building has no fire dampers. Van Guard provided paperwork verifying this on 11/25/2014.</p>	12/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2014
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K010069 SS=E	<p>close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects no residents in the unoccupied D Wing.</p> <p>Findings include:</p> <p>Based on record review on 11/05/14 at 9:30 a.m. with the maintenance supervisor, the maintenance supervisor indicated the D Wing had two fire dampers in the supply air ducts. Based on a records search on 11/05/14 at 9:45 a.m., the maintenance supervisor indicated there were no inspection records available for review for the two D Wing fire dampers. This was verified by the maintenance supervisor during the record review and acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking</p>	K010069	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Van Guard was called by the Maintenance Director to make a visit to inspect the range	12/03/2014

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	<p>Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review on 11/05/14 at 9:15 a.m., the only kitchen exhaust inspection records available for review were dated 08/17/14 and 08/27/13. Based on a tour of the kitchen with the maintenance supervisor, the kitchen exhaust hood had a sticker from the inspection company dated 08/17/14 with no previous semiannual inspection listed on the inspection tag. The lack of semi annual kitchen exhaust inspection for the first half of the year 2014 was verified by the maintenance supervisor at the time of record review and interview and</p>		<p>hood. Van Guard inspected the range hood and gave paper compliance on 11/25/2014. 2) 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 residents have the potential to be affected by the alleged deficient practice. Van Guard has inspected the range hood and provided paper compliance on 11/25/2014. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Routine visits by Van Guard to conduct inspections of the range hood per a schedule to stay compliant. 4) 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 in place. The required inspections will be monitored by the Maintenance Director and conducted by Van Guard to assure compliance. Any issues identified will be addressed timely by the Maintenance Director or/Designee. This will be review by the Quality Assurance Committee and action plans developed for any areas that needs to be address.</p>		

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	acknowledged by the administrator at the exit conference on 11/05/14 at 2:25 p.m. 3.1-19(b)				