DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING 9/6/11 B. WING MW	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 8/22/11 The following deficiencies were identified during the facility's annual licensure and certification survey conducted 8/1/11 - 8/4/11. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to display the results of Life Safety Code and all survey activity conducted in an area available to residents and the public. The facility reported a census of 101. Findings include: 1. Observation on 8/2/11 at 2:25 PM revealed a binder labeled "state survey results" in a holder behind the front reception desk approximately 60" (inches) from the floor. The binder failed to contain the results of the last annual survey and	F 167		

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.

POC accepted 9/16/11 NV Simmons

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F 248	Continued From page 2 mumbled words and usually could make his/herself understood. A MDS with an assessment reference date of 10/3/10 indicated staff interviewed the resident, who stated listening to music as very important to him/her and doing his/her favorite activity as somewhat important to him/her. Review of the resident's most recent Activity Questionnaire completed 1/14/09 revealed the resident's activity interests included pets, house plants, romance and comedy films, magazines, radio, TV, choir, religious and orchestra music, records, religious services and musicals. The Activity Coordinator documented Resident #8's lifelong interests included home, church and music. Review of an annual Activities Progress Note dated 10/13/10, the facility Activity Coordinator documented the resident continued his/her normal routines, an annual MDS completed and the resident's care plan updated. Review of Resident #8's Care Plan with a start date of 6/7/11 included an approach for staff to encourage the resident to attend activities of his/her choice. Further review of the resident's Activity Progress Notes revealed the following: On 1/11/11, the Activity Coordinator documented the resident had been in bed most of the time, but when he/she had been up, the staff assisted him/her to music programs and church. The Activity Coordinator documented the resident's	F 248		

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F 248	Continued From page 4 to music in his/her room, having someone read to him/her and/or having a church member coming to visit him/her. During interview on 8/3/11 at 12:35 PM, the Activity Coordinator confirmed Resident #8's activities needed to be increased and adapted to meet his/her needs. The Activity Coordinator confirmed the resident being involved in only 41 activities within 11 months and not a sufficient number of activities.	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain a sanitary and homelike environment in facility areas frequented by facility residents. The facility identified a census of 101. Findings include: 1. Environmental tour on 8/3/11 at 3:00 PM with the facility's administrator present revealed the following concerns: a. The E hall shower room with the cove base loose around the entire perimeter of the shower and black debris build-up in the corners; b. The toilet in the E hall shower room with a	F 252		

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F 252	Continued From page 6 paint.	F 252		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to follow physician orders for 1 of 18 active residents reviewed (Resident # 4). The facility reported a census of 101 residents. Findings included: According to a Minimum Data Set (MDS) assessment with a reference date of 3/29/11, Resident #4's diagnosis included diabetes, cerebrovascular accident or stroke, depression, renal failure and aphasia (inability to speak). The same MDS documented the resident as totally dependent on staff for bed mobility, transfers and dressing and with a Stage I pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence). According to a Skin Assessment for Pressure/Stasis/Arterial/Diabetic Decubitus form, with a first observed date of 10/20/10, Resident #4 developed an area on his/her left foot that measured 2 cm (centimeter) in size and purple in color. Further review of the resident's Skin Assessment forms dated 10/20/10 - 6/15/11, revealed the pressure area remained on the resident's left heel until healed on 6/15/11.	F 281		

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F 281	Continued From page 8 Observation on 8/2/11 at 1:44 PM, revealed Resident #4 sat in a wheelchair and had no Prafo boot on his/her left foot. The resident's heels pressed directly on a pillow under his/her heels. During interview on 8/3/11 at 12:15 PM, the facility Director of Nursing confirmed Resident #4 needed to have a Prafo boot on his/her left foot when up in a chair.	F 281		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		

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F 363	Continued From page 10 and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and facility record review, the facility failed to assure correct portions sizes served to residents with pureed diets. Additionally, based on observation and interviews the facility failed to consistently prepare enough food items so residents receive food items of their choice (Residents # 3 and #24). The facility identified a census of 101. Findings include: 1. The therapeutic spread sheet for the noon meal on 8/2/11 directed staff served a 4 ounce portion of meatloaf pureed, 4 ounces of corn pureed and 1 slice of bread with butter pureed in addition to other food items . Observation of pureed food preparation for the noon meal on 8/2/11 at 11:13 AM revealed Staff E, cook, stated she would prepare 10 servings of pureed foods. Staff E placed 10 4-ounce spoodles of corn into the Robot Coupe along with thickener and processed it. After preparation Staff E did not measure the total volume of the mixture. Staff E then placed 5 unweighed portions of meatloaf in the blender, processed it and measured the total volume as 3 cups. Staff E then placed another 5 unweighed portions of meatloaf in the blender, pureed them and measured the total volume as 3 1/2 cups for a total volume of 6 1/2 cups for division between 10 servings. Review of a standard pureed portion size determination chart identified staff use a #6	F 363		

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F 364	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and resident interviews, the facility failed to serve food at a proper temperature to assure palatability for 6 of 28 residents reviewed for dining service (#22, # 23, #24, # 28, # 30 and #31). The facility identified a census of 101. Findings include: 1. Observation of breakfast meal preparation and delivery on 8/3/11 revealed the following concerns: a. Observation of the room tray breakfast meal service on 8/3/11 starting at 8:15 AM revealed Staff I, dietary aide, identified he would prepare and deliver 8 room trays. Staff I prepared 8 plates of hot food from the steam table on unheated plates and placed them in unheated covers. Staff I then obtained drinks and placed them on each tray. b. At 8:18 AM, observation revealed a carton of yogurt on the room tray cart not kept cold. The Administrator measured the temperature of the yogurt at 50 degrees F (Farenheit) at this time, prior to the cart leaving the kitchen. Observation at 8:25 AM revealed the yogurt served to a resident. c. At 8:28 AM, Staff I delivered a tray to Resident #30. The temperature of the milk registered at 50 degreed F, the prune juice at 53 degrees F and oatmeal at 114 degrees F. Interview with resident revealed him/her to state the oatmeal cool and the juices warm.	F 364		

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F 364	Continued From page 14 2. During group interview on 8/2/11 at 1:40 PM, 2 of 3 residents present stated the had room tray service daily for breakfast. Both residents stated hot food items served are not consistently served hot. 3. During interview on 8/2/11 at 2:45 PM, Resident # 23 stated hot foods are not consistently served palatably hot. The resident stated s/he is assisted to eat in the main dining room. The resident further stated s/he served breakfast in his/her room on occasion and the hot food items are not hot.	F 364		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to assure pureed food items consistently prepared in palatable and safe manner for 9 of 9 residents served pureed diets. The facility identified a census of 101. Findings include: 1. The therapeutic spread sheet for the noon meal on 8/2/11 directed staff serve 4 ounces of pureed corn for residents with pureed diets. Observation of pureed corn preparation on 8/2/11 at 10:10 AM revealed Staff E, cook, identified 9 residents with pureed diets and she would prepare 10 servings. Staff E added 10 four	F 365		

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store, prepare and serve food under sanitary conditions to reduce the risk of food-borne illness. The facility identified a census of 101. Findings include: 1. During the initial kitchen tour on 8/1/11 at 11:32 AM, observation of a walk in cooler revealed the following: a. 2 carafes, approximately 1 quart in size each, contained amber colored fluid. The carafes lacked a label or date; b. A 1 gallon plastic bag contained a creamy light green substance. The bag lacked a label and date; c. A small stainless pan contained what appeared to be sausage links. The pan lacked a label and date; d. The entrance door of the freezer contained excess frost on the inside of the freezer door as well as the door frame. During interview on 8/1/11 at 11:50 AM, the facility Dietitian stated she had been concerned with the frost inside the freezer door as that usually meant things had been thawed and re-frozen. 2. Observation on 8/2/11 at 9:15 AM revealed 10 6-ounce cartons of yogurt on the counter in the kitchen. The cartons were not in ice. Observation at 10:00 AM revealed 6 cartons remained on the counter. At the request of the surveyor the facility's consulting dietician	F 371		

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F 371	Continued From page 18 flakes of lime in the water and the ice scoop stored in it. 5. Observation on 8/2/11 at 11:05 AM revealed Staff F, cook, entered the kitchen with no hair net on. Staff F walked around the kitchen, washed her hands and then donned a hair net. Staff F then proceeded to assist with making sandwiches. Observation revealed Staff F failed to wash her hands after handling her hair. 6. Observation on 8/2/11 at 11:13 AM revealed Staff H, dietary aide, cut slices of braunschweiger whiled she held the meat steady with one ungloved hand and the knife in the other ungloved hand. Staff H tore open the top of a sack of bread and obtained bread slices to make sandwiches. Observation revealed Staff H failed to wash her hands between handling meat and the bread. Staff E also made sandwiches and handled braunschweiger with gloved hands. Wearing the same gloves used to handle the meat, Staff E took the bread slices from the torn sack and placed then into another sack of bread, opened a can, and then pushed the sandwiches down into a container, obtained plastic wrap and covered them. 7. Observation on 8/2/11 at 11:20 AM revealed the following: a. Sheet pans in the oven had a heavy build-up of carbon on the inside surfaces. The pans contained pork patties. The stainless steel shelf above the stove contained a heavy amount of grease and debris; b. The grill surface observed soiled with dried food debris; c. The deep fat fryer contained a heavy amount	F 371		

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F 371	Continued From page 20 food debris on the bottom side and fiberglass spindle portion heavily stained and nicked; l. 6 food scoops stored as clean with food debris on the inside and outside surfaces. 9. Observation on 8/3/11 at 9:23 AM revealed a gallon of 2% milk, a 1/2 gallon of sweet Acidophilus milk, a carton of tomato juice and prune juice on a cart in the dining room. Observation at 10 AM revealed Staff I, dietary aide took the milk and juices taken to the kitchen. The temperature of the items measured as follows: a. Prune juice 52 degrees F; b. Tomato juice 54 degrees F; c. 2% milk at 54 degrees F; d. Sweet acidophilus milk at 46 degrees F. After measuring the temperature of the items, Staff I placed them into the walk-in cooler for reuse.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		

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F 431	Continued From page 22 b. 4 Levemir insulin flexpens with no date of opening and delivery dates of 4/28/11 (x2), 5/27/11 and 6/27/11. The manufacturer's (NovoNordisk) guidelines direct to discard 42 days after opening. 2. Observation of the south medication room on 8/2/11 at 9:00 AM revealed an open multidose vial of Flulaval (influenza vaccine) opened on 12/4/10. The bottle had an expiration date of 6/2011. The manufacturer's (GlaxoSmithKline) guidelines direct that once entered, the vial should be discarded after 28 days. 3. Observation of the North medication room on 8/3/11 at 10:10 AM with Staff C, registered nurse, present revealed the following concerns: a. Eleven unopened multi-dose vials of Flulaval influenza vaccine with an expiration date of 6/2011 indicated on each box; b. An open multidose vial of Aplisol (an injectable agent used to detect tuberculosis) with a delivery date of 5/17/11 and no date of opening indicated. The manufacturer's (JHP Pharmaceuticals) guidelines on the label directed that once entered the vial should be discarded after 30 days;	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		

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F 465	Continued From page 24 a. The tile backsplash, approximately 3' (feet) x 8', behind the juice and coffee machines in the main dining room with dried sticky substances and dust; b. An approximately 3' x 10' rubber-backed rug in front of the juice and coffee machine counter very soiled with spills and debris. The floor under this rug observed to be wet and odorous with a black substance and food debris on it; c. A rack clean dishware stored in the dining room prep area under a bug light which contained dead bugs; d. A plastic storage cupboard located in the dining room prep area which stored brooms and dust pans soiled with food debris. The bin had a foul odor; e. The door to the dish washer area with dried food debris and spills on the surface in an area approximately 24" x 36" (inches) at the bottom portion; f. Black debris around the bottom of the door jambs and floor between the dishwasher room door and kitchen entry door; g. A rubber-back rug in front of the ice machine wet and soiled with debris. the flooring under the rug observed discolored and odorous from the wetness; h. A rubber-backed rug in front of the sink in the dining room prep area with dried debris; i. An ice scoop holder attached to the ice machine contained a heavy build-up of lime on outside with streaks of lime down the side of the machine under this holder; j. The outside door at the end of G hall with scuffs and rust on the bottom edge. The scuffs covered an area approximately 36" x 18". The push bar to open the door noted to be soiled; k. The ceiling between rooms G 110 and 112	F 465		

F000
Preparation of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.

Subject to and without waiving the facility's right to formally or informally appeal this deficiency, the following is the facility's Plan of Correction.

F 167

Correct Deficiency as they relate to the individual
State survey results are placed in a binder holder on the wall in main entry way at a height that is compliant with ADA regulations.

Protect Residents in Similar Situations
State survey results are placed in a binder holder on the wall in main entry way at a height that is compliant with ADA regulations.

Systems we will alter to assure the problem does not recur
Administrator will update binder after each visit from DIA with the received CMS document 2567.

Plan to monitor performance to make sure that solutions are permanent
Guest relations staff member will check daily to ensure that the Survey Results Binder is located in the designated holder.

Date of Correction: 8/5/11

F 248

Correct Deficiency as they relate to the individual
Resident #8 is provided a program of activities designed to meet her needs.

Protect Residents in Similar Situations
Activities staff will provide activity programs to all residents that meet their needs and interests.

Systems we will alter to assure the problem does not recur
Activity staff will complete the activity interest surveys quarterly on all residents and will evaluate their personalized program so as to ensure that it meets their needs.

Plan to monitor performance to make sure that solutions are permanent
Activity director will complete random audits on resident activity records to ensure that the needs of residents are met.

Date of Correction: 8/26/11

F258

Correct Deficiency as they relate to the individual
The loose cove base is replaced. The black build up around the shower base is cleaned. The toilet in the shower room is clean. Liquid soap bags are installed properly into the dispenser and wall is free from drippage. The dining room floor is clean and not sticky. The wall by the PTAC unit in the Ginger Grove sun room is clean from black stains and does not have wall paper that is not attached to the wall. The Cherry blossom TV room wall is free from gouges and missing paint. The PTAC is fully insulated and no light from outside can be detected. Tiles are replaced in the closet in the TV room. The activity room in Cherry Blossom is free from clutter. They room is clean and bed tables are clean. There are no chairs that have chips or that are broken. The Cherry Blossom hall walls are clean. The ceiling on the hallway is clean. PTACS in the Cherry Blossom dining room are clean and free from missing paint.

Protect Residents in Similar Situations
An environmental walk through of the facility is conducted monthly. Audits of cleaning schedule are completed weekly.

Systems we will alter to assure the problem does not recur
These items are included on our monthly walk through.

Plan to monitor performance to make sure that solutions are permanent
Through daily and quarterly QA process we will ensure that these are permanent solutions.

Date of Correction: 8/26/11

F 281

Correct Deficiency as they relate to the individual
Resident #4 wears Prafo boot on his left foot when resident is sitting in a chair.

Protect Residents in Similar Situations
Physician orders for Prafo boots will be maintained in the Treatment Administration Record.

Systems we will alter to assure the problem does not recur
All staff were educated on 8/10/11 and 8/20/11 on following physician orders and the completion of treatments and recording treatments in the TAR.

Plan to monitor performance to make sure that solutions are permanent
TARS will be audited five times a week for four weeks.

Date of Correction: 8/30/11

F356

Correct Deficiency as they relate to the individual
The facility nurse staffing data is posted in the entry space of the facility at a height compatible with ADA standards.

Protect Residents in Similar Situations
The facility nurse staffing data is posted in the entry space of the facility at a height compatible with ADA standards.

Systems we will alter to assure the problem does not recur
The Director of Nursing will ensure that the data is posted in appropriate location.

Plan to monitor performance to make sure that solutions are permanent

The DON or designee will monitor that this has been a permanent correction by observing it being posted correctly weekly x4 weeks.

Date of Correction: 8/5/11

F 363

Correct Deficiency as they relate to the individual
Resident #24 receives food items as ordered on menu.
Resident #23 receives food items as ordered on menu.
Resident #3 receives food items as ordered on menu and receive appropriate amount of protein.

Protect Residents in Similar Situations
The facility will provide correct portions sizes to residents with puree diets. The facility will provide enough food items to ensure that residents have a choice of their meals.

Systems we will alter to assure the problem does not recur
Education was provided to dietary staff on 8/30/11 regarding meal choices and serving sizes .

Plan to monitor performance to make sure that solutions are permanent
A leadership team member or designee has been in the kitchen during all meals to assure proper choice and serving size. This will continue through 9/30/11.

Date of Correction: 8/31/11

F364

Correct Deficiency as they relate to the individual
Resident #30 receives meal at appropriate temperature.
Resident #22 receives meal at appropriate temperature.
Resident #24 receives meal at appropriate temperature.
Resident #31 receives meal at appropriate temperature.
Resident #23 receives meal at appropriate temperature.

Protect Residents in Similar Situations
Facility will serve food at proper temperature to all residents.

Systems we will alter to assure the problem does not recur
Education was provided to dietary staff on 8/9/11 and 8/30/11 regarding appropriate food temps and documentation of food temps at all meals daily.

Plan to monitor performance to make sure that solutions are permanent
Dietary walk through by the Registered Dietician or designee to monitor food temperature tracking will occur weekly x4.

Date of Correction: 8/31/11

F365

Correct Deficiency as they relate to the individual
Residents with pureed diets are served meal with proper consistency.

Protect Residents in Similar Situations
Residents with pureed diets are served meal with proper consistency.

Systems we will alter to assure the problem does not recur
Education was provided by the Registered Dietician and the Dietary Supervisor on Pureed consistency and serving sizes on 8/30/11.

Plan to monitor performance to make sure that solutions are permanent
Weekly walk throughs x4 weeks will monitor diets consistency and portion sizes and temperatures. Daily and monthly QA will monitor dietary concerns.

Date of Correction: 8/31/11

F371

Correct Deficiency as they relate to the individual
All items were cleaned. Glass board has been ordered and L&L Builders has been contracted to cover all kitchen wall space

Protect Residents in Similar Situations
A cleaning schedule was developed for all kitchen staff to participate in.

Systems we will alter to assure the problem does not recur
Daily monitoring of kitchen cleanliness will be performed by the cooks and dietary supervisor. Education was provided to all dietary staff on 8-30-11 regarding kitchen cleaning and sanitation.

Plan to monitor performance to make sure that solutions are permanent
Weekly kitchen environmental audits will be performed to assure cleaning compliance.

Date of Correction: 8/31/11

F 431

Correct Deficiency as they relate to the individual
Expired medications are removed from storage.

Protect Residents in Similar Situations
Medication storage are free from expired medication.

Systems we will alter to assure the problem does not recur
Pharmacy sends the flex pens with red date stickers on them as well as a tamper resistant sticker. When sticker is broken nurse will know to put the date on the red opened sticker. Education was provided to all nurses regarding expired medications and the flex pens with red stickers on 8/25/11.

Plan to monitor performance to make sure that solutions are permanent
Medical Records Staff will audit for expired medications in the cupboards in the med rooms and the DON or designee will audit the refrigerators and med carts for expired medications as well as the dates on the flex pens weekly x4 weeeks.

Date of Correction: 8/30/11

F465

Correct Deficiency as they relate to the individual
All areas are cleaned and sanitized.

Protect Residents in Similar Situations
A cleaning schedule was developed for all kitchen staff to participate in.

Systems we will alter to assure the problem does not recur
Daily monitoring of kitchen cleanliness will be performed by the cooks and dietary supervisor. Daily walk through of the facility by maintenance supervisor will ensure cleanliness and maintenance of facility structure. Education was provided by the Registered Dietician on 8-30-11 regarding the cleaning schedule, kitchen cleanliness and sanitation and repair of kitchen items.

Plan to monitor performance to make sure that solutions are permanent
Weekly kitchen environmental audits will be performed to assure cleaning compliance.

Date of Correction: 8/31/11