

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

PRINTED: 05/18/2015  
FORM APPROVED  
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

025010

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

05/07/2015

NAME OF PROVIDER OR SUPPLIER

KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

3100 TONGASS AVENUE  
KETCHIKAN, AK 99901

(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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 5/3-7/15. The sample included 10 sampled residents, 1 of which was a closed record, and 4 non-sampled residents.</p> <p>Abbreviations used in this document:</p> <p>DON Director of Nursing FSM Food Services Manager CMS Centers for Medicare and Medicaid Services MOS Minimum Data Set</p> <p>Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503</p>	F 000		
F 159 SS=F	<p><b>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of</p>	F 159	<p><b>RECEIVED</b></p> <p>JUN 01 2015</p> <p>ALASKA DEPT OF HEALTH &amp; SOCIAL SERVICES HEALTHCARE SERVICES</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

*Sherrill Lytle*

TITLE

VP Patient Care Services, NHA 5/29/15

(X6) DATE

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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F 159	<p>Continued From page 1</p> <p>the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 159	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">JUN 01 2015</p> <p style="text-align: center;"><b>ALASKA DEPT OF HEALTH &amp; SOCIAL SERVICES HEALTHCARE SERVICES</b></p>	

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F 159	<p>Continued From page 2</p> <p>Based on observation, interview, and record review, the facility failed to ensure access to petty cash (funds less than \$50) at all times. This failed practice placed 5 residents (#s 8, 11, 12, 13, and 14) at risk for not receiving cash within the same day the money was requested (based on a census of 22). Findings:</p> <p>Observation on 5/5/15 at 11:38 am revealed resident petty cash funds were being kept in individual envelopes in a locked safe located behind the central nurses' station. The safe held petty cash for residents (#s 8, 11, 12, 13, and 14).</p> <p>During an interview on 5/5/15 at 11:38 am the Activities Coordinator was asked about residents' petty cash. She stated she and the DON were the only staff with access to the residents' petty cash. The Surveyor asked if the residents would have access to their petty cash during times when the Activities Coordinator and DON were not there; such as evenings, weekends and holidays. She stated the residents would not have access during those times.</p> <p>During an interview on 5/7/15 at 9:50 am the DON was asked who had access to the resident's petty cash. He stated he and the Activity Coordinator had access to the petty cash safe. In addition, he believed the Charge Nurse also had access to the petty cash safe. The Surveyor asked if the residents would have access to their petty cash during times when the DON, Activities Coordinator and Charge Nurse were not available; such as evenings, weekends and holidays. The DON acknowledged there was a fault in the process of accessing petty cash and residents would not have access during those times.</p>	F 159	<p><b>Immediate Corrective Action:</b> Procedure put in place that allows all residents that participate in the funds management program to access funds 24hrs per day / 7 days per week.</p> <p><b>Potential other affected residents identified:</b> This includes all residents that participate in the funds management program</p> <p><b>Corrective Measures:</b> Policy and associated procedure will be modified to provide for 24/access to petty cash funds. During other than regular business hours or at any time the D.O.N., Activities Coordinator or Charge Nurse are all absent at the same time, the House Supervisor will have access to the petty cash funds and will distribute those funds as per policy.</p> <p><b>Monitoring / Evaluation:</b> The D.O.N. will investigate any resident complaint, family complaint or staff report of a resident, that participates in the fund management program, not getting a petty cash funds withdrawal request on the same day it was requested.</p> <p style="text-align: right;">RECEIVED JUN 01 2015 ALASKA DEPT OF HEALTH &amp; SOCIAL SERVICES HEALTHCARE SERVICES</p>	6/21/15

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F 159	Continued From page 3	F 159		
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F 278 SS= F	<p>Record review on 5/7/15 of the facility's "Resident Funds Management" policy, <i>effective</i> date 7/23/14, revealed "Funds up to the amount on deposit in the petty cash account, by an individual resident, will be available to that resident on the day of request."</p> <p>483.20(g) - U) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each</p>	F 278	<p>RECEIVED</p> <p>JUN 01 2015</p> <p>ALASKA DEPT OF HEALTH &amp; SOCIAL SERVICES HEALTHCARE SERVICES</p>	
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F 278

Continued From page 4 assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview the facility failed to ensure the CMS-802 accurately represented the resident's status for 21 residents (based on a sample of 22 residents). Without accurate pertinent care categories and characteristics, information populated by the MOS, residents were at risk for not receiving the necessary and/or appropriate care and services. Findings:

During the initial portion of the survey, on 5/3/15, the Surveyors requested a current CMS-802 from the facility. A CMS-802 is a form used to list all current residents and to note pertinent care categories. The facility was to complete the residents' names, residents' rooms, and columns 6-30. Columns 6-30 are resident characteristics.

Review of the CMS-802 on 5/3/15, provided by the facility, revealed 14 residents with no pertinent care categories or characteristics. It also revealed 7 residents with 1 or 2 pertinent care categories or characteristics.

During an interview on 5/4/15 at 7:30 am the MOS Coordinator was asked about the lack of care categories and characteristics on the facilities CMS-802. She said the CMS-802 was not correct. She provided the Surveyors with a CMS-802 which she did by hand. She stated the

F 278

**Immediate Corrective Action:**  
When this error in the form 802 was pointed out, the MDS RN Coordinator immediately collected and reported the data by hand completing a form 802 that was accurate and up to date.

**Potential other affected residents identified:**  
As this is a report of all the residents in the facility, this has the potential to affect all residents of the facility.

**Corrective Measures:**  
Shortcomings in current software configuration preclude auto population and compilation on demand therefore, a new procedure will be implemented until software is obtained that will allow for automated data compilation. The MDS RN Coordinator will update the form-802 manually once per week and more often as necessary, such as admissions, discharges or significant change in the status of a resident.

**Monitoring / Evaluation:**  
The procedure will include a copy of the form 802 being delivered to the D.O.N. each time the data is updated (at least weekly). This will allow the D.O.N. to monitor compliance with the update requirements noted above.

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F 278	Continued From page 5 software they were using for populating the CMS-802 from the MDS information was not functioning.			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by:  Based on observation, interview, and record review the facility failed to ensure: 1) grease did not build up in the kitchen; 2) scoops did not remain in dry food containers; and 3) foods were not accessible for use after the expiration date. These failed practices created a potential for food contamination and increased the risk for food-borne illness (based on a census of 22). Findings:  Observations in the kitchen on 5/3/15 at 2:05 pm revealed a buildup of grease on the floor behind the grill. Further observations revealed a scoop in the flour bin.	F 371	<b>Immediate Corrective Action:</b> 1) Grease was immediately cleaned 2) This was immediately removed when the Kitchen Manager became aware of it. 3) "foods were not accessible for use after the expiration date." Outdated food items were identified and discarded <b>Potential other affected residents identified:</b> 1) & 2) As all residents food is prepared in this main facility kitchen, these would have the potential to affect all residents. 3) "foods were not accessible for use after the expiration date." As the activities kitchen is a common area that most residents have access to, this had the potential to affect all residents of the facility.	6/21/15

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			<p><b>Corrective Measures:</b></p> <ol style="list-style-type: none"> <li>1) A work-order was placed to repair the faulty part which was causing a grease leak. Staff were instructed on the importance of moving equipment when cleaning the floors, which would have made them aware of this problem. A written process will be circulated among the kitchen and housekeeping staff, detailing this and which will become a read and sign document, making the employee responsible for having the correct knowledge, as to cleaning.</li> <li>2) A placard was created and placed on the bin to serve as a job aide reminding staff to not leave scoops in the bins. Procedures were reviewed with the cooks.</li> <li>3) "foods were not accessible for use after the expiration date." <ul style="list-style-type: none"> <li>➤ Current Policy and associated Procedures will be modified and / or new Policy and associated Procedures initiated to ensure that food stuffs not supplied and monitored by the main facility kitchen are monitored for outdate.</li> </ul> </li> </ol>	21 June 2015

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371	<p>Continued From page 6</p> <p>Observations in the activity kitchen cupboard on 5/3/15 at 3:15 pm revealed a loaf of sliced white bread and a loaf of brown bread dated, 4/21/15.</p> <p>During an interview on 5/5/15 at 9:30 am the Food Service Manager was asked when bread should be thrown away if it had a store label date of 4/21/15. He stated it was to be thrown away on 4/21/15.</p> <p>In the same interview the FSM was asked how long scoops should be left in a flour bin and he stated no scoops were to be left in a bin.</p> <p>During continued interview with the FSM he stated the grease should be cleaned at least daily and/as needed throughout the day.</p> <p>Record review of the facility policy "Floor Stock and Nursing Unit Refrigerators," dated 11/11/10, revealed, "[Food] Items with code dates are to be disposed of when outdated."</p>	F 371	<p><b>Monitoring / Evaluation:</b></p> <ol style="list-style-type: none"><li>1) This will become a part of the Kitchen Manager's daily walk around monitoring of the department. Any infraction will be immediately corrected.</li><li>2) This is already a part of the Kitchen Manager's departmental rounding program. He had, discovered and corrected this on his next round. Any further findings of this sort will be immediately corrected and responsible staff counseled.</li><li>3) "foods were not accessible for use after the expiration date."<ul style="list-style-type: none"><li>➤ Included as a part of the above policy and associated procedure, a process will be defined for assigning accountability and a reporting process to the Quality Committee.</li></ul></li></ol>	21Jun2015
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<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. Continued From page 7</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to have a process in place to identify and dispose of expired medications for multiple residents. As a result, residents were at risk of receiving outdated, potentially sub-therapeutic medications (based on a census of 22). Findings:</p> <p>Multiple observations on 5/5/15 from 8:27 am to 9:59 am of the medication room revealed multiple expired medications found in resident specific drawers of the Pyxis Medstation Carefusion (lockable machine that logs medication dispensing, as well as, stores resident specific medications).</p> <p>During an interview on 5/5/15 at 9:20 am the Charge Nurse confirmed the medications found in the resident specific drawers of the Pyxis were expired. When asked who was responsible for monitoring outdated medications, the Charge Nurse stated it was the nursing staffs'</p>	<p>F-425</p>	<p><b>Immediate Corrective Action:</b> Outdated medications were removed from resident drawers in the Pyxis medication safe.</p> <p><b>Potential other affected residents identified:</b> Because all resident medications are managed in the same manner this had the potential to affect any resident with medications being stored in a personal drawer.</p> <p><b>Corrective Measures:</b> A policy and associated procedure will be instituted to ensure that Resident supplied medications are managed in a safe and appropriate manner, including a monthly check for outdated items..</p> <p><b>Monitoring / Evaluation:</b> Included as a part of the above policy and associated procedure, a process will be defined for assigning accountability for the management of resident supplied medications, and for incorporation into the facilities Quality Monitoring program with reporting to the Quality Committee.</p>	<p>21Jun2015</p>
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F 425	Continued From page 8 responsibility to check for expiration dates.  During an interview on 5/5/15 at 10:03 am, Pharmacist #1 stated that once a medication was placed in the resident specific drawers of the Pyxis, it was the long term care facility's staffs that were responsible for monitoring the expiration dates.  Record review on 5/6/15 of the facility's "Inspection of Medication Storage Areas" pharmacy policy, last reviewed 7/29/14, revealed "The Pharmacy Department shall assure monthly inspections of all medication areas are completed by either the pharmacy department or the unit."			
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview, and record review, the facility failed to monitor maintenance and housekeeping functions so that a sanitary and comfortable environment for residents was maintained. Specifically, the facility failed to ensure:			

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F 465	<p>Continued From page 9</p> <p>1) the Sara lift was cleaned after each use; 2) suction equipment was regularly cleaned; 3) electrodes were stored for safe use; 4) chipped counter laminate was replaced; and 5) Purell hand sanitizers had drip plates;</p> <p>These failed practices had the potential to affect the comfort and safety of residents (based on a census of 22). Findings:</p> <p>Sara Lift</p> <p>Observations on 5/3/15 at 3: 10 pm and 5/4/15 at 9:50 am, revealed a Sara lift (used to assist residents with standing, sitting, and transfer), located in the activity room, had dried secretions, dirt, and debris on the hand grips, hand bars, and foot platform.</p> <p>During an interview on 5/4/15 at 9:00 am the Activity Coordinator was asked if the Sara lift located in the Activity room was clean. She stated it should be because it was to be cleaned after each use.</p> <p>During this same interview the Activity Coordinator and this Surveyor looked at the Sara lift. She confirmed the Sara lift was not clean and it should have been cleaned after it had been last used. In addition, when asked, she stated the nursing staff and/ or the activity staff was responsible for cleaning the lift after each resident use.</p> <p>During an interview on 5/5/15 at 10:20 am the Environmental Service Manager was asked who was responsible for cleaning the Sara lift. He stated it was a nursing staffs' responsibility.</p>	F 465	<p><b>Immediate Corrective Action:</b></p> <p>"Specifically, the facility failed to ensure:</p> <p>1) the Sara lift was cleaned after each use; 2) suction equipment was regularly cleaned; 3) electrodes were stored for safe use; 4) chipped counter laminate was replaced; and 5) Purell hand sanitizers had drip plates;"</p> <ul style="list-style-type: none"> <li>➤ The Sara Lift and suction equipment were immediately cleaned. Verbal instructions were issued to clean the Sara Lift after each use and to monitor the cleanliness of the suction machine, located on the emergency cart, daily when the integrity of the cart is checked</li> <li>➤ All electrodes on the emergency cart were discarded and replaced with unopened packages of new electrodes. Verbal instructions were issued that no open packages of electrodes were to be kept, regardless of the number remaining in the package. They were to be discarded</li> <li>➤ Laminated countertops were taken out of service for all resident related food use, for those food items not in an unopened and sealed container. They will remain out of service until such time as they can be replaced.</li> </ul>	6/21/15

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ALASKA DEPT OF HEALTH  
& SOCIAL SERVICES  
HEALTHCARE SERVICES

*SW*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  KETCHIKAN MED CTR NEW HORIZONS TRANSITIONAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 TONGASS AVENUE KETCHIKAN, AK 99901	

(X4) ID PREFI XTAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI XTAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE	(X5) COMPLETION DATE
F 465	<p>Continued From page 10</p> <p>Emergency Cart</p> <p>Observation on 5/3/15 at 3:10 pm revealed the suction machine on the emergency cart, located in the hall alcove, had dust covering the suction canister and machine. In addition an opened package of electrodes was on top of the cart.</p> <p>Observation on 5/5/15 at 2:00 pm, after the emergency cart had been restocked by LN #1 and placed back in the hall alcove the suction canister and machine remained covered in dust. In addition, the electrodes remained opened.</p> <p>During an interview on 5/5/15 at 2:50 pm, the Charge Nurse stated the suction equipment was not on a cleaning schedule but should be free of dust. In addition, he stated it would be expected that the entire cart, to include the suction machine, would be cleaned when the emergency cart was restocked.</p> <p>During this same interview the Charge Nurse stated the facility did not have a policy on the storage and safe use of electrodes after opening.</p> <p>Chipped Laminate</p> <p>Observations from 5/3-7/15 revealed chipped laminate strips on the activity kitchen island counter.</p> <p>During an interview on 5/7/15 at 10:35 am the Maintenance Director was made aware of the chipped laminate and stated that it could be</p>	F 465	<p>➤ Purell hand sanitizers were taken out of service and emptied and will remain out of service until such time as they can be modified to come into compliance. Of note, this action presents no hazard to resident safety as there are existing manual type hand sanitizer containers in each resident room, at the nurses station and in the various resident activities rooms and restrooms.</p> <p><b>Potential other affected residents identified:</b> These deficiencies had the potential to affect all residents of the facility.</p> <p><b>Corrective Measures:</b></p> <p>➤ A process will be instituted that places the Sara Lift, suction equipment and other resident use equipment on regular inspection and cleaning schedule with accountability assigned.</p> <p><b>Monitoring / Evaluation: Sara Lift</b></p> <p>➤ A process for monitoring compliance will be incorporated into the facilities existing Quality Management program with reporting to the Quality Committee.</p>	21Jun2015

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F 465

Continued From page 11

Purell Hand Sanitizer

Observations from 5/3-7/15 revealed multiple Purell hand sanitizers mounted outside each resident room and in various other corridor locations. In addition, multiple sanitizers had leaked a pile of hand sanitizer solution on hand rails and/or on the walls and floor. No drip plates were present on any of the hand sanitizers.

During an interview on 5/4/15 at 11:25 am the Charge Nurse was asked about the drip piles of hand sanitizer observed in multiple locations on the hand rails. He stated staff tries to keep the piles of sanitizer wiped up\_

During an interview on 5/7/15 at 8:15 am the Maintenance Director confirmed the hand sanitizers had been leaking on the hand rails; walls; and floor since they were installed over a year ago.

F 465

**Corrective Measures (continued):**

- To preclude the retaining of open packages of electrodes, products that are provided in smaller packaging will be obtained. Further, the emergency cart will be placarded with a reminder to discard all open packages of single use items, including electrodes, regardless of the amount left in the open package.

21Jun2015

**Monitoring / Evaluation: Electrodes**

- A check for open electrode packages will be made a part of the daily emergency cart check

**Chipped Laminate**

- New counter tops have been ordered for the Activities Kitchen and will be installed upon arrival. Until that installation, counter tops will remain out of service for use with resident food items, not in an unopened and sealed container.

30July2015

**We are requesting an extension until 30 July 2015 to allow time for the new counter tops be fabricated and installed, based upon contractor schedule.**

- Purell, auto-dispense hand sanitizers were taken out of services and emptied. They will remain out of service until such time as parts can be obtained to modify them such that they come into compliance.

30July2015

**We are requesting an extension until 30 July 2015 to allow time for the parts required to modify the dispensers to be shipped to Ketchikan and installed.**

**Monitoring / Evaluation:**

- Periodic spot checks will be conducted to determine that the modifications applied to the dispensers contain any leak that may occur.

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