THE LAURELS & THE HAVEN
IN THE
VILLAGE AT CAROLINA PLACE

FIVE STAR
SENIOR LIVING

September 4, 2019

Dennis Harrell
Biennial Institutional Engineering Surveyor
DHSR – Construction Section

Re: The Haven in the Village at Carolina Place – HA Biennial Survey
13150 Dorman Rd.
Pineville, NC 28134
Mecklenburg County
FID# 971417 License #: HAL-060-104

Enclosed is the response from The Haven in the Village at Carolina Place for each rule violation/deficiency cited during the Biennial Construction Survey completed on August 14, 2019.

Respectfully,

Shay Lingerfelt
Executive Director

Enclosures

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060107	A. BUILDING: 01 B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA P	13150 DORMAN ROAD PINEVILLE, NC 28134

(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) COMPLETE DATE
C 000	Initial Comments Report of Construction Section Biennial Survey by Dennis Harrell on 8-14-2019: Records indicate this facility was first licensed on 1-1-1997. The facility is currently licensed as a SIXTY BED SPECIAL CARE UNIT Facility. Therefore, we are requiring that this facility to meet the 1996 Rules for the Licensing of Adult Care Homes and the applicable portions of the 2005 Licensing Rules and the 1996 edition of the North Carolina State Building Code Volume I - General Construction - Section 409 Institutional Occupancy (Group I). Deficiencies were cited.	C 000	See Attached	
C 101	Existing Licensed Fac- No less than '71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost; This Rule is not met as evidenced by:	C 101		

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C 101	Continued From page 1 1. Based on observation and interview, most staff were unaware of the location or the use or even the existence of the required emergency release switch for the Special (magnetic) Locking at each exit door. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment. 2. Based on observation, this facility failed to meet the NC State Building Code requirements for Special Locking (magnetic locks) on the exit doors. The Code requires, "If any required emergency release switch is of the locking type, all staff must carry emergency release switch keys." Finding on 8-14-2019: The required emergency release switch located at each magnetically locked exit door was of the locking type. Staff did not carry release switch keys. 3. Based on observation and interview, all staff were unaware of the location or the use or even the existence of the required central emergency release switch for the Special (magnetic) Locking on all the exit doors. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment. 4. Based on observation, the facility failed to meet the NC State Building Code in effect at the time of construction by not having all of the required components for doors with Special Locking System. The required central emergency release switch must be labeled as such. Finding on 8-14-2019: The central emergency release switch on the Special Care side was labeled wrong as "Fire". 5. Based on observation and interview, all staff	C 101	See Attached.	

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C 101	Continued From page 2 were unaware of the location or the use or even the existence of the key to reset the central emergency release switch for the Special (magnetic) Locking. The reset key happened to be stored in a drawer just below the switch and was found by accident after the surveyor informed staff that a key was required. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment. 6. Based on observation, the Building did not meet the code requirements in effect at the time of initial Licensing or alteration, by not providing all required exits or exit access doors with exit signs. This could affect residents, staff, and visitors by not providing egress directions for a prompt evacuation of the building. Finding on 8-14-2019: There are 2 corridor exits and 2 other doors leading into the large entrance foyer at the front door. The exit leads through an interior door into a vestibule and then through an exterior door. The exit path is a required exit. No exit sign is provided over the interior door and the exit sign over the exterior door is not visible from most of the foyer.	C 101	See Attached.	
C 166	Housekeeping-Maintained Free of Hazards SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; (e) This Rule shall apply to new and existing facilities.	C 166		

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C 166	Continued From page 3 This Rule is not met as evidenced by: 2. Based on observation, the waste trap for the hopper had been allowed to become dry. Dry waste traps allow noxious, combustible odors and possibly harmful bacteria to enter the facility. 3. Based on observation, an extension cord was being used in place of permanent wiring and was run through a door from the Community room to a storage space. Extension cords are intended for temporary use only and must never pass through a doorway. 4. Based on observation, the cord to a CD player was run through a door from the corridor to the Ice Cream Parlor. Cords must never pass through a doorway. Note; This deficiency was corrected during the survey.	C 166	See Attached.	
C 184	Fire Safety-Evacuation plan SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0309 PLAN FOR EVACUATION (a) A written fire evacuation plan (including a diagrammed drawing) which has the written approval of the local Code Enforcement Official shall be prepared in large print and posted in a central location on each floor of an adult care home. The plan shall be reviewed with each resident on admission and shall be a part of the orientation for all new staff. (f) This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 1. Based on observation and interview, the	C 184		

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C 184	Continued From page 4 exterior evacuation paths were not clearly defined or communicated. Findings on 8-14-2019; a. The exits from Asheville, Charlotte and Wilmington lead to angular courtyards. There were not exit signs in the courtyards to clarify the intended exit path. It was not clear from observation or interview with staff if the gates are intended to be used during evacuation. The gates were not easily visible or located. It took a few minutes to find the gates in the day light. In the confusion of an evacuation at night, finding the gates would be very difficult. b. The exit path from Asheville Community was overgrown with a tree limb hanging to just 3 feet above the side walk. c. The exit gates from the courtyards were secured with padlocks. Staff did not carry keys to the locks	C 184	See Attached.	
C 189	Building Equipment Maintained Safe, Operating SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: 1. Based on observation, one of the required emergency release switches in Wilmington Community was broken. A broken switch could delay or prevent an evacuation in an emergency.	C 189		

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C 189	Continued From page 5 2. Based on observation, many corridor doors are prevented from closing quickly and latching to resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings on 8-14-2019; a. The closer is disconnected on the 3/4 hour fire door to the laundry. b. The double doors to the Community room cannot latch because the latchbolt was removed. c. The rated door to the laundry in the Charlotte Community was propped open. Note; This deficiency was corrected during the survey. d. The door to the employee breakroom is dragging and hard to close and latch. e. The door to the Administrative area is dragging and hard to close and latch. f. The door to the moproom was wedged open. g. The door to the Ice Cream Parlor was wedged open. h. Two doors to activity closets on the Charlotte Community were disabled from latching with tape over the strike. Note; These deficiencies were corrected during the survey. 3. Based on observation, the required one-hour fire rated walls and/or ceilings were compromised in locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings on 8-14-2019: a. Holes in the wall of the BOM office, b. Holes in the wall of the copy area, c. Holes in the wall of the riser room.	C 189	See Attached.	

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C 189	Continued From page 6 4. Based on observation, the facility was not maintained in a safe condition because of improper storage too close to a fire sprinkler head. Storage that is not kept at least 18 inches below the sprinkler head could negate the ability of the fire sprinkler system to extinguish a fire. Finding on 8-14-2019; Storage had been stacked to within 5 inches of the ceiling in the storage closet off the Community room.	C 189	See Attached.	

The Haven in the Village at Carolina Place
HA Biennial Construction Survey
Plan of Correction
Facility License # HAL-060-107

1) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation and interview, most staff were unaware of the location or the use or even the existence of the required emergency release switch for the Special (magnetic) Locking at each exit door. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The current emergency release switches will be replaced by 9/28/19 with standard switches that do not require a key to operate. The standard switches will have clear breakaway covers over them to ensure all staff have access but also prevent accidental release by residents.

All SCU staff will be trained by 9/28/19 on the use of the emergency release switch for the Special Locking at each exit door.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

Once new switches are installed the Maintenance Director or designee will conduct random visual inspections to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

2) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation, this facility failed to meet the NC State Building Code requirements for Special Locking (magnetic locks) on the exit doors. The Code requires, "If any required emergency release switch is of the locking type, all staff must carry emergency release switch keys." Finding on 8-14-2019: The required emergency release switch located at each magnetically locked exit door was of the locking type. Staff did not carry release switch keys.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The current emergency release switches will be replaced by 9/28/19 with standard switches that do not require a key to operate. The standard switches will have clear breakaway covers over them to ensure all staff have access but also prevent accidental release by residents.

All SCU staff will be trained by 9/28/19 on the use of the emergency release switch for the Special Locking at each exit door.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

Once new switches are installed the Maintenance Director or designee will conduct random visual inspections to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

3) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation and interview, all staff were unaware of the location or the use or even the existence of the required central emergency release switch for the Special (magnetic) Locking on all the exit doors. All staff responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

All SCU staff will be trained by 9/11/19 on the use of the central emergency release switch for the Special Locking on all the exit doors.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

4) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation, the facility failed to meet the NC State Building Code in effect at the time of construction by not having all of the required components for doors with Special Locking System. The required central emergency release switch must be labeled as such. Finding on 8-14-2019: The central emergency release switch on the Special Care side was labeled wrong as "Fire".

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The central emergency release switch on the Special Care side will be correctly labeled by 9/11/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

5) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation and interview, all staff were unaware of the location or the use or even the existence of the key to reset the central emergency release switch for the Special (magnetic) Locking. The reset key happened to be stored in a drawer just below the switch and was found by accident after the surveyor informed staff that a key was required. All staff

responsible for evacuation in an emergency must be properly trained in evacuation procedures and equipment.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

All SCU staff will be trained by 9/28/19 on the use of the emergency release switch for the Special Locking at each exit door.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random verbal surveys of the SCU staff to ensure compliance. Additionally, the community will conduct training for all new staff upon hire during orientation.

6) 10A NCAC 13F .0301 Application of Physical Plant Requirements – Based on observation, the Building did not meet the code requirements in effect at the time of initial Licensing or alteration, by not providing all required exits or exit access doors with exit signs. This could affect residents, staff, and visitors by not providing egress directions for a prompt evacuation of the building. Finding on 8-14-2019: There are 2 corridor exits and 2 other doors leading into the large entrance foyer at the front door. The exit leads through an interior door into a vestibule and then through an exterior door. The exit path is a required exit. No exit sign is provided over the interior door and the exit sign over the exterior door is not visible from most of the foyer.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

An exit sign over the Interior Door will be installed by 9/28/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will ensure an exit sign is installed over the interior door.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will ensure an exit sign is installed over the interior door.

7) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on observation, the waste trap for the hopper had been allowed to become dry. Dry waste traps allow noxious, combustible odors and possibly harmful bacteria to enter the facility.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The hopper will be serviced/used weekly by the Housekeeping team to ensure compliance.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine inspections of the hopper to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine inspections of the hopper to ensure compliance.

8) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on observation, an extension cord was being used in place of permanent wiring and was run through a door from the Community room to a storage space. Extension cords are intended for temporary use only and must never pass through a doorway.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The identified extension cord was removed on 8/14/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director conducted a community wide inspection to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational checks/inspections to ensure compliance.

9) 10A NCAC 13F .0306 Housekeeping and Furnishings – Based on observation, the cord to a CD player was run through a door from the corridor to the Ice Cream Parlor. Cords must never pass through a doorway. Note; this deficiency was corrected during the survey.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The identified extension cord was removed on 8/14/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director conducted a community wide inspection to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational checks/inspections to ensure compliance.

10) 10A NCAC 13F .0309 Plan for Evacuation – Based on observation and interview, the exterior evacuation paths were not clearly defined or communicated. Findings on 8-14-2019;

a. The exits from Asheville, Charlotte and Wilmington lead to angular courtyards. There were not exit signs in the courtyards to clarify the intended exit path. It was not clear from observation or interview with staff if the gates are intended to be

used during evacuation. The gates were not easily visible or located. It took a few minutes to find the gates in the day light. In the confusion of an evacuation at night, finding the gates would be very difficult.

b. The exit path from Asheville Community was overgrown with a tree limb hanging to just 3 feet above the side walk.

c. The exit gates from the courtyards were secured with padlocks. Staff did not carry keys to the locks.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. The exits from Asheville, Charlotte and Wilmington courtyards. Exit signs will be installed on the courtyard gates. Additionally, all SCU staff will be trained by 9/28/19 on the proper egress route in the courtyards to exit.

b. The exit path from Asheville Community – the trees and shrubs were trimmed on 8/30/19.

c. The exit gates from the courtyards were secured with padlocks – a magnetic locking system with a keypad will be installed on each courtyard gate by 9/28/19. All SCU staff will be trained on how to use the new locking system after installed.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine operational checks/inspections of the SCU courtyards to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Executive Director or designee will conduct routine operational checks/inspections of the SCU courtyards to ensure compliance.

11) 10A NCAC 13F .0311 Other Requirements – Based on observation, one of the required emergency release switches in Wilmington Community was broken. A broken switch could delay or prevent an evacuation in an emergency.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The broken emergency release switch will be replaced by 9/28/19 with a standard switch that does not require a key to operate. The standard switch will have clear breakaway cover over it to ensure all staff have access but also prevent accidental release by residents.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

Once new switches are installed the Maintenance Director or designee will conduct random visual inspections to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct random visual inspections to ensure compliance.

~~12) 10A NCAC 13F .0311 Other Requirements – Based on observation, many corridor~~ **doors are prevented from closing quickly and latching to resist the passage of fire and smoke. Corridor doors that do not close completely and latch present the possibility that a fire that begins in one space can quickly spread to the corridor and the remainder of the facility. Findings on 8-14-2019;**

a. The closer is disconnected on the 3/4 hour fire door to the laundry.
b. The double doors to the Community room cannot latch because the latch bolt was removed.
c. The rated door to the laundry in the Charlotte Community was propped open. Note; this deficiency was corrected during the survey.
d. The door to the employee breakroom is dragging and hard to close and latch.
e. The door to the Administrative area is dragging and hard to close and latch.
f. The door to the mop room was wedged open.
g. The door to the Ice Cream Parlor was wedged open.
h. Two doors to activity closets on the Charlotte Community were disabled from latching with tape over the strike. Note; these deficiencies were corrected during the survey.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. The closer is disconnected on the 3/4 hour fire door to the laundry – will be repaired by 9/28/19.
b. The double doors to the Community room cannot latch because the latch bolt was removed – will be repaired by 9/28/19.

c. The rated door to the laundry in the Charlotte Community was propped open. Note; this deficiency was corrected during the survey.
d. The door to the employee breakroom is dragging and hard to close and latch – will be repaired by 9/28/19.
e. The door to the Administrative area is dragging and hard to close and latch – will be repaired by 9/28/19.
f. The door to the mop room was wedged open – will be repaired by 9/28/19.
g. The door to the Ice Cream Parlor was wedged open – will be repaired by 9/28/19.
h. Two doors to activity closets on the Charlotte Community were disabled from latching with tape over the strike. Note; these deficiencies were corrected during the survey.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct a community wide inspection of all corridor doors by 9/28/19 to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine operational checks/inspections of corridor doors to ensure compliance.

13) 10A NCAC 13F .0311 Other Requirements – Based on observation, the required one-hour fire rated walls and/or ceilings were compromised in locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings on 8-14-2019:

a. Holes in the wall of the BOM office,
b. Holes in the wall of the copy area,
c. Holes in the wall of the riser room.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

a. Holes in the wall of the BOM office – repaired on 8/28/19.
b. Holes in the wall of the copy area – repaired on 8/28/19.
c. Holes in the wall of the riser room – repaired on 8/28/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine inspections of the one hour fire rated walls and ceilings to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine inspections of the one hour fire rated walls and ceilings to ensure compliance.

14) 10A NCAC 13F .0311 Other Requirements – Based on observation, the facility was not maintained in a safe condition because of improper storage too close to a fire sprinkler head. Storage that is not kept at least 18 inches below the sprinkler head could negate the ability of the fire sprinkler system to extinguish a fire. Finding on 8-14-2019; Storage had been stacked to within 5 inches of the ceiling in the storage closet off the Community room.

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

The identified storage was removed on 8/14/19.

B) Other residents potentially affected by the same alleged deficient practice will be identified as follows:

All SCU residents could potentially be affected.

C) The following systemic changes will be made to ensure compliance with this regulation:

The Maintenance Director or designee will conduct routine inspections of all storage areas to ensure compliance.

D) The facility will monitor the corrective actions as follows:

The Maintenance Director or designee will conduct routine inspections of all storage areas to ensure compliance.

Respectfully,

Shay Lingerfelt
Executive Director