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

PRINTED: 01/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185301</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/03/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4804 LOWE RD LOUISVILLE, KY 40220</b>
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F 000	INITIAL COMMENTS  An abbreviated survey was initiated on 12/20/11 and concluded on 01/03/12 to investigate KY17531. The Division of Health Care substantiated the allegation as verified by the evidence. Federal and State deficiencies were cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regis Woods Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."  F314	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy for Skin Care & Pressure Ulcer Management, it was determined the facility failed to provide necessary treatment and services to promote healing, and prevent infection for one (1) of four (4) sampled residents. Resident #1 did not receive wound care treatment on two (2) consecutive occasions which resulted in a need for hospitalization and surgical treatment.  The findings include:  Review of the facility's policy for Skin Care & Pressure Ulcer Management revealed the nursing team managed wound care as defined by the	F 314	1. Resident #1 was transferred to the hospital on 12-10-11 and returned to the facility on 12-16-11 with new treatment orders for the wound. The dressings are changed as ordered. RN #1 is no longer employed at the center.  2. Treatment orders for current residents were reviewed to determine that wound care treatments were implemented as ordered by the Director of Nursing, Assistant Director of Nursing and Unit Managers as of 12-12-2011.  3. A KCI wound nurse re-educated the Staff Development Coordinator regarding wound vac treatment and procedures on 1-24-2012. Licensed nursing staff will be re-educated and complete return demonstrations of	

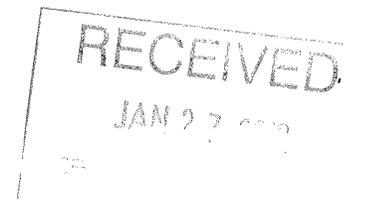
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Joseph Gault TITLE: X Administrator (X6) DATE: X 1/27/2012

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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F 314	<p>Continued From page 1</p> <p>physician order, and the licensed nurse was responsible to follow the schedule for changing of dressings.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 11/26/11 with diagnoses of Motor Vehicle Accident, Multiple Fractures, Methicillin Resistant Staph Aureus (MRSA) of the left lower leg wound. A physician order, dated 11/30/11, revealed Adaptic Non-Adhering Dressing and Oasis dressing covered with a small vacuum sponge and an adaptic dressing to the left lower leg with a wound-vac (vacuum) to be changed every two (2) days. Review of the Treatment Administration Record (TAR) revealed the dressing was documented as changed on 12/04/11 and was due to be changed on 12/06/11 and 12/08/11. The TAR showed the dressing was not initialed by the nurse as completed on 12/06/11 and 12/08/11. The resident was transferred to a local hospital on 12/10/11 for evaluation of the left lower wound, and was then discharged from the hospital to the facility on 12/16/11 with status-post Cellulitis of the left lower leg and debridement of the left lower leg wound.</p> <p>Interview, on 12/20/11 at 12:00 PM, with the Assistant Director of Nursing (ADON) revealed RN #1 did not document the dressing changes were completed on 12/06/11 and 12/08/11 for Resident #1 as ordered. The ADON said the wound sponge/dressing could not be removed from the wound on 12/10/11, and Resident #1 was sent to the hospital for evaluation of the left lower leg wound. The DON said she spoke with RN #1 by phone to inquire why the dressings were not changed on 12/06/11 and 12/08/11 and</p>	F 314	<p>wound vac treatments by 1-29-2012.</p> <p>Licensed nurses will be re-educated on providing and documenting treatments and services to promote healing and prevent infection by the Staff Development Coordinator, Assistant Director of Nursing and Unit Managers by 1-29-2012.</p> <p>4. Treatment Administration Records will be reviewed on 6 residents with wounds twice a week x 12 weeks to determine that treatments are completed as ordered by the Director of Nursing, Assistant Director of Nursing, Unit Managers and Staff Development Coordinator. A summary of findings will be submitted to the Performance Improvement Committee monthly times three months for further review and recommendation.</p> <p>5. Date of compliance 1/30/2012.</p>		



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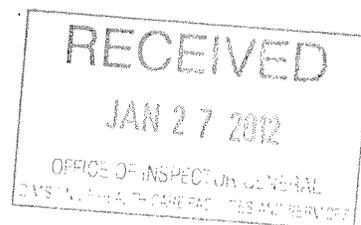
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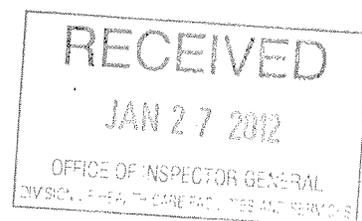
F 314	<p>Continued From page 2</p> <p>was told by RN #1 that he "did not have time" to get them done because he "was too busy." The ADON reported that RN #1 said he did not advise his supervisor or the nurse in shift report of the dressing changes which were not completed.</p> <p>Interview, on 12/21/11 at 8:00 AM, with the Unit Manager (UM) revealed he received a phone call at home on 12/10/11 from the ADON who advised him Resident #1 had been transferred to the hospital because staff were unable to remove the sponge/dressing from the left lower leg. The UM said RN #1 did not request assistance on 12/06/11 or 12/08/11 and did not advise him the dressings changes for Resident #1 had not been completed. The UM said he was responsible to ensure that all treatments were completed as the physician ordered, and used a log to document the most current condition of each wound which was provided to the ADON each Friday. The UM said he did not review the wound log and did not provide the current wound measurements to the ADON on Friday, 12/09/11.</p> <p>Interview, on 12/21/11 at 1:10 PM, with RN #1 revealed he did not do the dressing changes for Resident #1 on 12/06/11 and 12/08/11 as ordered. RN #1 said he was not aware he was responsible to change the dressings for Resident #1. RN #1 said he did not have much experience with the wound-vac dressing that Resident #1 required and assumed there would be a Wound Care Nurse at the facility to do the dressing because the dressing required special training. RN #1 said he gave report to the UM because the facility was not fully staffed on 12/06/11, and told the UM in report that he only had time to complete the medication passes. RN #1 said he</p>	F 314		
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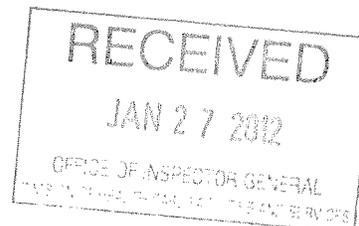
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F 314	<p>Continued From page 3</p> <p>did not specifically request assistance on 12/06/11 or 12/08/11, but said the staff knew he was frustrated because he could not get his work done.</p> <p>Interview, on 12/21/11 at 1:30 PM, with the Staff Development Coordinator revealed staff were not trained during orientation to perform the wound-vac dressing changes. Staff nurses were expected to find a staff member who was experienced with the procedure to assist and teach the procedure. The SDC said RN #1 was an experienced nurse who had been working at the facility for two (2) months, but did not have much long term care experience. The SDC thought RN #1 may have thought the facility utilized a treatment nurse to perform the wound-vac dressing changes. The SDC said RN #1 was not assigned to a preceptor upon completion of orientation, and said RN #1 was not familiar with the TAR. The SDC said the facility did not observe or document the competency of nurses to complete the wound-vac dressing change.</p> <p>Interview, on 12/22/11 at 1:25 PM, with the Director of Nursing (DON) revealed the UM was responsible to ensure all treatments were completed as ordered, to compile the weekly wound measurements, and to provide the wound condition report to the ADON. The ADON was responsible to review, evaluate healing, and determine if a resident needed further intervention. The facility did not utilize a tool or log for the ADON to document the weekly review.</p> <p>Interview, on 12/22/11 at 2:00 PM, with the Administrator revealed RN #1 neglected to report</p>	F 314			



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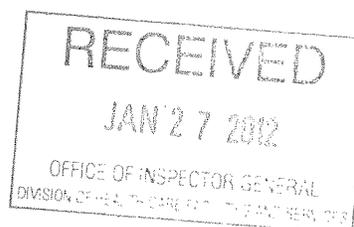
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F 314	Continued From page 4 wound care for Resident #1 as not completed, and said that RN #1 told him that he knew he needed to change the dressings but ran out of time. The Administrator considered the failure to change Resident #1's dressings on 12/06/11 and 12/08/11 as willful neglect because as a nurse, RN #1 understood the consequences of the failure to perform the dressing changes.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F441  1. Resident #1 was discharged from the center on 1-13-2012. Resident #4 no longer requires contact isolation as of 12-21-11. Resident #3 wound was assessed on 12-28-11 by a licensed nurse and wounds were noted to be healing with no signs or symptoms of infection. The dressing cart was cleaned and all products discarded and replaced at no cost to the resident to avoid risk of cross contamination by a licensed nurse on 1-23-2012. The COTA was re-educated regarding Infection Control procedures related to isolation on 12-21-11 by the Staff Development Coordinator. LPN #3 and #4 were verbally educated on 12-21-11 re-educated on Infection Control procedures related to isolation as of 1-29-12 by the Staff Development Coordinator.  2. Current residents with wounds were identified and assessed for new symptoms of infection on 12-10-11 by the licensed nurse. No new symptoms were identified.	



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F 441	Continued From page 5 hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for Infection Control, it was determined the facility failed to establish and maintain an Infection Control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for two (2) of four (4) sampled residents. The facility staff failed to enter and exit the contact isolation room of Resident #1 utilizing personal protective equipment (PPE) and handwashing. The facility staff failed to prevent cross contamination when dressing supplies used in Resident #1's contact isolation room were returned to the dressing cart. The facility staff failed to wash their hands when changing from dirty gloves and applying clean gloves. The facility staff failed to maintain a clean-field during a dressing change for Resident #4 by allowing unrestrained hair to fall down onto the resident's bed, dressing scissors, gloved hands, and the dressing supplies.  The findings include:	F 441	3. Therapy, housekeeping, laundry, and nursing staff will be re-educated by 1-29-2012 on the Infection Control policy and procedures and included, personal protective equipment, isolation precautions, potential for cross contamination, hand washing and maintaining a clean field during dressing changes.  4. The Staff Development Coordinator or Assistant Director of Nursing will observe dressing changes on 2 residents twice a week x 12 weeks to determine that infection control practices are being performed during dressing changes to include hand washing and maintaining a clean field. The Staff Development Coordinator or Assistant Director of Nursing will complete random rounds for observation of residents in contact precautions weekly for 12 weeks to determine that infection control practices are implemented to include utilizing personal protective equipment, hand washing, and preventing cross contamination with dressing supplies. A summary of these findings will be submitted to the Performance Improvement Committee by the Staff Development Coordinator or Assistant Director of Nursing monthly times three months for further review and recommendation.  5. Date of compliance 1/30/2012.		



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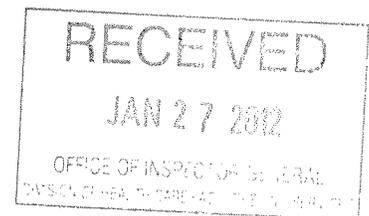
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F 441	<p>Continued From page 6</p> <p>Review of the facility's policy for Infection Control revealed hands were to be washed upon removal of gloves. The Infection Control policy stated Methicillin Resistant Staff Aureus (MRSA) infections were managed with Contact Isolation Procedures which included the use of gloves and gowns to prevent contact with environmental surfaces or resident care items to prevent cross-contamination. Section 10: Precaution Guidelines for standard precautions, detailed instruction for staff to change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms, and to wash hands immediately upon removal of gloves to avoid transfer of microorganisms to other residents or environmental surfaces.</p> <p>Interview, on 12/21/11 at 1:30 PM, with the SDC revealed staff were trained to wash their hands each time gloves were removed. The SDC stated that hands should be washed between tasks, and it would be necessary to wash the hands after removing a dressing to avoid cross-contamination.</p> <p>1. Review of the clinical record for Resident #1 revealed an admission date of 11/26/11 with diagnoses of a recent Motor Vehicle Accident with Multiple Fractures and MRSA of the left lower leg wound. A physician order, dated 12/19/11, revealed Contact Isolation Precautions for Resident #1 for a diagnosis of MRSA.</p> <p>Observation, on 12/20/11 at 11:45 AM, revealed Resident #1 was sitting on the side of the bed with the Certified Occupational Therapy Aide (COTA) at bedside performing therapy exercises.</p>	F 441		
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F 441	<p>Continued From page 7</p> <p>The COTA was not wearing PPE (gown or gloves).</p> <p>Observation, on 12/21/11 at 9:35 AM, revealed the COTA was standing at the bedside of Resident #1 who was in contact isolation precautions, and was not wearing PPE. The COTA moved the bedside table to a convenient position for Resident #1, and stood close to the bed with clothing touching the bed as she spoke with Resident #1. The COTA closed the resident's bathroom door, and exited the room without washing their hands.</p> <p>Observation, on 12/22/11 at 8:30 AM, of care for Resident #1, provided by LPN #4 revealed an intravenous infusion alarmed in the contact isolation room. LPN #4 entered the room to silence the alarm without the use of PPE, then exited the room. The alarm sounded again and LPN #4 entered the isolation room, to silence the alarm without the use of PPE.</p> <p>Interview, on 12/22/11 at 9:15 AM with LPN #4 revealed he did not always wear gloves and gown in contact isolation and said it was not necessary to wear gown and gloves each time the he entered the room.</p> <p>Interview, on 12/22/11 at 9:25 AM, with the COTA revealed she had been employed by the facility for two (2) months and was not provided an Infection Control in-service. The COTA said she did not wear gloves during the treatment of Resident #1 because she always used bleach wipes to clean the equipment before taking it out of the isolation room. The COTA said it was not necessary to wash the hands before leaving the</p>	F 441		
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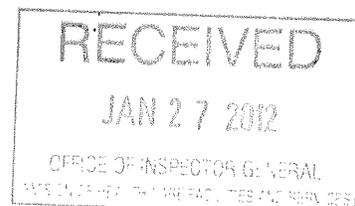
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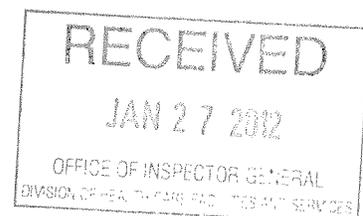
F 441	<p>Continued From page 8</p> <p>room. The COTA said that gowns are only worn into the isolation room if there is a likely risk of soiling.</p> <p>Interview, on 12/22/11 at 9:30 AM, with the Occupational Therapist (OT) revealed in contact isolation precautions a gown and gloves should be worn and said this information was presented to all therapy staff, on 12/21/11 at 3:00 PM, when the Staff Development Coordinator (SDC) presented an Infection Control In-Service. The OT stated that hands should be washed before leaving the contact isolation room.</p> <p>Interview, on 12/21/11 at 1:30 PM, with the SDC revealed she functioned as the Infection Control Nurse in the facility. The SDC said the Physical Therapy staff were a contracted company, with a new manager, and said they did not seem to get much training with regard to Infection Control. The SDC said in contact isolation, staff should always wear gloves, and if it was likely the staff would contact surfaces in the room, a gown should be worn. The SDC said staff should remove all PPE, and the hands should be washed before the room was exited.</p> <p>2. Observation, on 12/22/11 at 9:10 AM, of wound care for Resident #1, provided by LPN #4 revealed supplies for the dressing changes were removed from the dressing cart and taken into the contact isolation room of Resident #1. Upon completion of the dressing change, a bottle of iodine and a bottle of 1/8 strength Dakins solution were removed from the isolation room and returned to the treatment cart by LPN #4.</p> <p>Interview, on 12/22/11 at 9:15 AM, with LPN #4</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/03/2012
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(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 441	<p>Continued From page 9</p> <p>revealed the nurse returned the iodine and bottle of 1/8 strength Daklins to the treatment cart because it did not present any risk of cross-contamination.</p> <p>Interview, on 12/22/11 at 9:45 AM, with the SDC revealed staff were trained to avoid taking supplies into the contact isolation environment to prevent cross-contamination. The SDC said the appropriate amount of solution or ointment needed should be poured into a disposable cup or onto the dressing supplies before it was taken into the room for use. The SDC said it was not an acceptable practice to remove supplies from contact isolation and replace them on the dressing cart.</p> <p>Interview, on 12/22/11 at 1:25 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed supplies should not be returned to the treatment cart from an isolation room. The DON stated supplies returned to the treatment cart from an isolation room was a cross-contamination risk.</p> <p>3. Observation, on 12/21/11 at 9:30 AM, of wound care for Resident #1, provided by LPN #3 revealed the nurse wore gloves to remove the dressing from the left lower extremity, then removed the gloves and put on gloves the nurse had stored in the pocket of their scrubs. The nurse did not wash their hands before the gloves were applied to replace the dressing.</p> <p>Observation, on 12/21/11 at 10:30 AM, of wound care for Resident #3, provided by LPN #3, revealed the nurse wore gloves to remove a dressing, then applied clean gloves without</p>	F 441			



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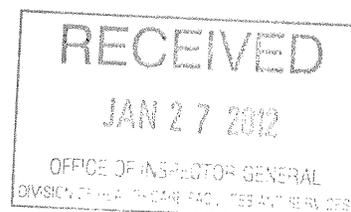
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NAME OF PROVIDER OR SUPPLIER  <b>REGIS WOODS CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4804 LOWE RD LOUISVILLE, KY 40220</b>
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F 441	<p>Continued From page 10 handwashing.</p> <p>Review of the clinical record for Resident #3 revealed an admission date of 10/21/11 with diagnoses of Hip Fracture, Difficulty Walking, Pain, and a Heel Wound. A physician order, dated 10/05/11, revealed daily wound care to the left heel.</p> <p>Interview, on 12/21/11 at 10:45 AM, with LPN #3 revealed that the nurse said staff should wash the hands when gloves were removed and was not aware she neglected to wash the hands upon removal of gloves during the dressing change for Resident #1 and Resident #3. LPN #3 said the gloves stored in the scrub pocket were clean.</p> <p>Observation, on 12/22/11 at 8:45 AM, of wound care for Resident #1, provided by LPN #4 revealed the nurse removed gloves after a dressing was removed from a wound on the left lower leg. LPN #4 did not wash their hands after the dirty gloves were removed then put on clean gloves and provided wound care to the left heel.</p> <p>Interview, on 12/22/11 at 9:15 AM, with LPN #4 revealed it was not necessary to wash hands when gloves were removed if the hands were washed before the gloves were worn. LPN #4 said he did not wash his hands after the dressing for Resident #1 was removed because he washed before the clean gloves were worn, and said, "everything was clean" after he washed his hands when he entered the room.</p> <p>Interview, on 12/22/11 at 1:25 PM with the DON and ADON revealed staff were trained to wash their hands before and after gloves were worn.</p>	F 441		
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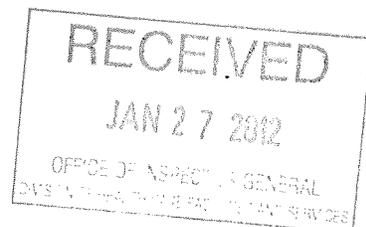
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F 441	<p>Continued From page 11</p> <p>The DON said hands should be washed before wearing clean gloves to avoid cross-contamination.</p> <p>4. Review of the facility record for Resident #4 revealed an admission date of 06/28/11 with diagnoses of Peripheral Vascular Disease, Diabetes Type II, and Lower Limb Amputation. The physician order's revealed wound care to the right below the knee amputation every three days.</p> <p>Observation, on 12/21/11 at 10:55 AM, of wound care for Resident #4, provided by LPN #2, revealed that during the wound dressing change, the unrestrained hair of LPN #2, fell onto the resident's bed, the dressing scissors, her gloved hands, and the clean dressing supplies which were applied to the wound base.</p> <p>Interview, on 12/21/11 at 11:30 AM, with LPN #2 revealed she was not aware her hair touched the bed of Resident #4, the dressing scissors, gloved hands, or the clean dressing supplies. LPN #2 said she usually wore her hair pulled back, but was unable to do so on this day because she chose to wear a decorative holiday hat which did not accommodate a hair restraint. LPN #2 said if the hair touched the items during the wound care, it would be a source of cross-contamination to the wound.</p> <p>Interview, on 12/22/11 at 9:45 AM, with the SDC revealed staff were trained to keep their hair restrained to avoid cross-contamination, and said this was a basic principle taught in nursing school curriculum.</p> <p>Interview, on 12/22/11 at 1:25 PM, with the DON</p>	F 441		
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F 441	Continued From page 12 and ADON revealed staff were expected to wear long hair pulled back and the DON said the nurse's unrestrained hair was a potential source of contamination.	F 441		
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