STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 01 B. WING	02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

(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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/01/17 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent Healthcare of Owensville, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 68	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and had a census of 51 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 02/07/17 - DA			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly for 30 seconds and annually for 90 minutes during 10 of the past 12 months to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of	K 0291	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective 02-20-17 to the state findings of the Life Safety Code Survey	02/20/2017

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	1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 02/01/17 at 11:00 a.m. with the Maintenance Supervisor present, the Battery Operated Emergency Light Test Log for 2016 and 2017 indicated the battery operated emergency lights were only tested in January and February of 2016. Furthermore, there was no documentation to show the battery operated emergency lights were tested annually for 90 minutes. Based on an interview at the time of record review, the Maintenance Supervisor said there was no other documentation available to show the battery operated emergency lights were tested during any other months except January and February of 2016. Furthermore, there was no documentation to show a 90 minute annual test was performed during the past twelve months. 3.1-19(b)		conducted on February 1, 2017. K 291 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents have the potential to be affected by the deficient practice. All of the facility battery operated back up lights have been visually inspected and have been tested for 90 minutes and were found to be functioning properly. This inspection and testing has been documented in the facility maintenance files and will remain on file for future inspections.	

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			*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that*all residents have the potential to be affected by this deficient practice. All of the facility battery operated back up lights have been visually inspected and have been tested for 90 minutes and were found to be functioning properly. This inspection and testing has been documented in the facility maintenance files and will remain on file for future inspections. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility is currently recruiting for a new Maintenance Supervisor.	

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			Upon hire that individual will be thoroughly trained on the required visual checking and testing of the battery operated back up lights. Until such time the company area Maintenance Supervisor will be responsible to ensure that the battery operated back up lights are visually checked and the required testing has been completed and documented in accordance with life safety codes. *The corrective action taken to monitor to assure compliance is that* the facility has adopted the practice that the Maintenance supervisor will submit to the Executive Director monthly the documents supporting that the appropriate testing of the battery operated back up lights has been completed. The Executive Director will review and	

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			initial the documents validating that the supportive documentation is on file in accordance with life safety code. If there are any concerns identified by the Executive Director at the time of this review, they will be immediately addressed and corrected.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/01/17 at 12:00 p.m. with the Maintenance Supervisor present, there was	K 0353	K 353 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified as having been affected by this deficient practice however all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has conducted a thorough sprinkler system inspection which included all sprinkler heads, all gauges and control valves. The fire department connections have been inspected and tested including the valves, valve components and trim. All sprinkler heads have been inspected and are free of any paint or debris. All components of the facility sprinkler system were found to be in good condition and in proper functioning order. This inspection is documented in	02/20/2017

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	documentation available from Tri State Fire Protection that quarterly sprinkler inspections were performed on 03/30/16, 06/01/16, 09/23/16 and 12/28/16. Weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review. Furthermore, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Maintenance Supervisor indicated the facility performs regular visual sprinkler system inspections but does not document sprinkler system gauge and system control valves inspections and acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:15 p.m. to 2:30 p.m. the facility has a total of three pressure gauges at the sprinkler riser. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 400 sprinkler heads in the facility were free of		the facility sprinkler system inspection log and is being maintained in accordance with life safety code. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents, staff and visitors have the potential to be affect by this deficient practice.* The facility has conducted a thorough sprinkler system inspection which included all sprinkler heads, all gauges and control valves. The fire department connections have been inspected and tested including the valves, valve components and trim. All components of the facility sprinkler system were found to be in good condition and in proper functioning order. This inspection is documented in the facility sprinkler system inspection log and is being maintained in accordance with life safety code.	

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	paint. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect mostly staff while in the time clock room, plus any other residents, staff or visitor while in the front entrance smoke compartment. Findings include: Based on observation on 02/01/17 at 1:10 p.m. during a tour of the facility with the Maintenance Supervisor, there was one sprinkler head in the time clock room with paint covering the fusible link portion of the sprinkler head. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		*The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility is currently recruiting for a new Maintenance Supervisor. Upon hire that individual will be thoroughly trained on the required on the facilities weekly sprinkler system inspection and testing process. Until such time the company area Maintenance Supervisor will be responsible to ensure that the facility sprinkler system is inspected and tested in accordance with life safety code and facility practices.	

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			The corrective action taken to monitor to assure compliance is that has adopted the practice that the Maintenance supervisor will submit to the Executive Director monthly the documents supporting that the appropriate weekly and monthly inspections and testing of the facility sprinkler system have been completed in accordance with life safety code and facility practices. The Executive Director will review and initial the documents validating that the supportive documentation is on file in accordance with life safety code. If there are any concerns identified by the Executive Director at the time of this review, they will be immediately addressed and corrected.	

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 2 of 11 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators.	K 0355	K 355 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the portable fire extinguishers located by the beauty shop and in the therapy department have now been inspected and are in good condition and proper functioning order. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide inspection of all portable fire extinguishers has been conducted and all portable fire extinguishers are in good condition and proper functioning order.	02/20/2017

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	Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could residents, as well as staff and visitors while in the Physical Therapy area and the Beauty Shop. Findings include: Based on observations on 02/01/17 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the monthly inspection tag on the fire extinguisher located in the Beauty Shop lacked documentation of monthly inspections for July through December of 2016. Furthermore, the monthly inspection tag		*The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility has adopted a practice whereby upon completion of the monthly fire extinguisher inspection in addition to the maintenance supervisor marking the fire extinguisher tag upon inspection, the maintenance supervisor will maintain a fire extinguisher log documenting the date of the inspection, any corrective action required and their initials. The maintenance supervisor will be required to maintain these documents in their records for at least 12 months.	

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	on the fire extinguisher located in the water heater closet in the Physical Therapy area lacked documentation of monthly inspections for July through December of 2016, and January of 2017. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)		*The corrective action taken to monitor to assure compliance is that* the maintenance supervisor will submit the completed fire extinguisher log to the Executive Director monthly for review. The Executive Director will review and initial the documents validating that the supportive documentation is on file in accordance with life safety code. If there are any concerns identified by the Executive Director at	

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			the time of this review, they will be immediately addressed and corrected.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 2 areas open to the corridor was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice	K 0361	K 361 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however staff, visitors and up to 22 residents have the potential to be affected by this deficient practice. An electrically supervised smoke detector has been installed in the southwest lounge area outside the beauty shop and is functioning properly.	02/20/2017

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	could affect staff and up to 22 residents, staff and visitors in the west hall smoke compartment. Findings include: Based on observation on 02/01/17 at 12:40 p.m. during a tour of the facility with the Maintenance Supervisor, the southwest lounge outside the Beauty Shop was open to the corridor. Furthermore, LSC 19.3.6.1(7) was not met because the southwest lounge outside the Beauty Shop was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide assessment was completed to ensure that all spaces open to the corridor are protected by an electrically supervised smoke detector. All areas were found to be protected by an electrically supervised smoke detector. *The measures that have been put into place to ensure that the deficient practice does not recur is that* all areas open to the corridor are being monitored monthly by the maintenance supervisor as part of the preventative maintenance program to ensure that these areas that open into the corridor are being monitored by an electrically supervised smoke detector which is functioning properly. This	

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			monitoring will be documented in the smoke detector monitoring log weekly by the maintenance supervisor. *The corrective action taken to monitor to assure compliance is that* the maintenance supervisor will submit the completed smoke detector monitoring log to the Executive Director monthly for review to ensure that all areas open to the corridors are being monitored by an	

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			electrically supervised smoke detector that is functioning properly. If there are any concerns identified by the Executive Director at the time of this review, they will be immediately addressed and corrected.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of electrical wire	K 0372	K372	02/20/2017

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	and sprinkler pipe through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observations on 02/01/17 between 1:45 p.m. and 2:15 p.m. during a tour of the facility with the Maintenance Supervisor, the following unsealed penetrations were discovered: a) a four inch gap around a four inch sprinkler pipe in the east side smoke barrier wall b) a one foot by one and a half foot hole through the wall with insulated wrapped electrical wire running through the hole in the wall, plus a three inch gap around a four inch sprinkler pipe penetrating the wall Based on interview at the time of observations, the Maintenance Supervisor acknowledged each aforementioned condition. 3.1-19(b)		*The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents, staff and visitors have the potential to be affected by this deficient practice. The four inch gap around the four inch sprinkler pipe in the east side smoke barrier wall has been properly sealed to prevent the spread of smoke/fire. The one foot by one and a half foot hole through the wall which insulated wrapped electrical wire running through the hole in the wall plus the three inch gap around a four inch sprinkler pipe which was penetrating the wall has been properly sealed to prevent the spread of smoke/fire. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a	

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			housewide inspection has been completed of all smoke barrier walls and no other holes/gaps were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility has adopted the practice that all smoke barrier walls will be inspected monthly by the maintenance supervisor to ensure there are no holes/gaps. Any identified breaches in the smoke barrier walls will be repaired immediately upon identification. This inspection will be documented monthly by the maintenance supervisor.	

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			The corrective action taken to monitor to assure compliance is that the maintenance supervisor will submit the smoke barrier wall inspection to the Executive Director monthly for his review. If there are any concerns identified by the Executive Director at the time of this review, they will be immediately addressed and corrected.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that			

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	drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 02/01/17 at 11:30 a.m. with the Maintenance Supervisor present, three of four third shift (night) fire drills were performed between 10:16 p.m. and 10:33 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the third shift fire drills were performed and agreed the times were not varied enough. 3-1.19(b)	K 0712	K 712 *The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however all residents, staff and visitors could potentially be affected by this deficient practice. Fire drills have been conducted on all three shifts at varied times to establish a baseline. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. Fire drills	02/20/2017

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			have been conducted on all three shifts at varied times to establish a baseline. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the facility has developed a practice that fire drills will be conducted on each shift each quarter. The fire drills will occur on at least a two hour difference time schedule than from the previous fire drill conducted on that shift. *The corrective action taken to monitor to assure compliance is that* the maintenance supervisor will submit the fire drill schedule to the Executive Director monthly for review to ensure that fire drills are being held at varied times in accordance with the facility practice. If there are any concerns identified by the Executive Director at the	

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			time of this review, they will be immediately addressed and corrected.	
K 0912 SS=D Bldg. 01	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 5 wet location resident care areas was provided with ground fault circuit interrupter	K 0912	K 912 *The corrective action taken*	02/20/2017

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	(GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the DNS office. Findings include: Based on observation on 02/01/17 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the DNS Office had two electric receptacles within four feet of a sink with no ground fault circuit interrupter on the electric outlets. This was confirmed when testing with a GFCI testing device. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		*for those residents found to have been affected by the deficient practice is that* no specific residents were identified during the survey however the staff in the DNS office could potentially be affected by this deficient practice. The facility has covered the identified electrical receptacle in the DNS office with a flat plate cover to prevent exposure/access to the electrical outlet. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide inspection of all electrical receptacles, located in what is defined as a wet location to ensure that they have a ground fault circuit interrupter to protect against electric shock has been completed. No other receptacles were identified during this inspection	

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			The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has implemented the practice as part of the preventative maintenance program that a monthly inspection of electrical receptacles will be conducted by the maintenance supervisor to ensure that the receptacles identified as being in a wet location are provided with a ground fault circuit interrupter to protect against electric shock or they are covered with a flat plate cover to prevent exposure/access to the electrical outlet.	

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			The corrective action taken to monitor to assure compliance is that the maintenance supervisor will provide the Executive Director with the monthly electrical receptacle inspection report for his review. If there are any concerns identified by the Executive Director at the time of this review, they will be immediately addressed and corrected.	