STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G256	A. BUILDING -- B. WING	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CRF INC	6155 W 800 N FOUNTAINTOWN, IN 46130

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/08/21 Facility Number: 000776 Provider Number: 15G256 AIM Number: 100243510 At this Emergency Preparedness survey, Residential CRF Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 02/10/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey conducted was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/08/21 Facility Number: 000776 Provider Number: 15G256 AIM Number: 100243510 At this Life Safety Code survey, Residential	K 0000		

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

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	CRF, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be nonsprinklered. The facility has a fire alarm system with heat detection in the attic; smoke detection in corridors and all living areas. The facility has a battery operated smoke detector installed in the staff bedroom. The facility has a capacity of 6 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1. Quality Review completed on 02/10/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers were installed in accordance with NFPA 10. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of	K S100	The ABC portable fire extinguisher in the kitchen will be properly mounted and secured. The supervisor will monitor through monthly QA checks to	03/10/2021

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	protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.4 requires that portable fire extinguishers shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the ABC type portable fire extinguisher located in the kitchen pantry was standing upright on a shelf and was not supported or secured. Based on interview at the time of the observations, the Administrator agreed the portable fire extinguisher was not supported or secured. This finding was reviewed with the Administrator at the exit conference.		assure that this deficient practice is not repeated. Any fire extinguisher found to not be properly mounted will be corrected immediately. Responsible: Supervisor, House Staff	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to			

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	allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 4 paths of travel to a means of escape were not less than 28 inches wide. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the width in the path of egress to the exit door to the outside of the facility from the laundry room measured 24 inches wide between the corridor wall and the freezer. The measurement was made with a measuring tape. Based on interview at the time of the observations, the Administrator agreed the aforementioned means of escape in the laundry was less than 28 inches wide.	K S222	The freezer which was impeding the width of the egress path will be moved to a different location to allow for an egress path of 28 inches or greater. Staff and supervisor will monitor so not items block the egress paths of all exits. Further, supervisor will monitor and address during monthly QA checks to assure that exits are properly maintained clear of obstructions. Responsible: Maintenance, Supervisor, House staff	03/10/2021

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	This finding was reviewed with the Administrator during the exit conference.			
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable			

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	where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used.			

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	33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 3 client sleeping rooms was provided with a secondary means of escape in accordance with 33.2.2.3. LSC Section 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect at least 2 clients. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the northwest bedroom had one window. The horizontal sliding window pane for the window measured 18 inches wide by 41 inches high when in the fully opened position. The measurements were made with a measuring tape. The clear opening was calculated to be 5.1 square feet when in the fully open position. Based on interview at the time of the observations, the Administrator agreed the aforementioned secondary means of egress did not provide a clear opening of not less than 20 inches wide and did not provide a clear opening of not less than 5.7 square feet with the window in the fully open position. This finding was reviewed with the Administrator during the exit conference.	K S253	Maintenance has been advised of this issue and has made preparation to install an appropriate window in the home which will open properly to meet standards. The window replacement will be completed as quickly as possible to correct this deficiency. Responsible: Supervisor, Maintenance	03/10/2021
K S300 Bldg. 01	NFPA 101 Protection - Other Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with			

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	the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure the preventative maintenance for 1 of 1 battery operated smoke alarms in 1 of 1 staff sleeping rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the staff sleeping room on the west side of the building had a wall mounted battery operated smoke detector installed above the corridor door in the room but the smoke detector was out of date. Manufacturer's information affixed to the back of the Fire Sentry Model 0914 smoke detector indicated it was manufactured May 16, 2007 and to "replace the detector after 10 years". Based on interview at the time of the observations, the Administrator stated the facility was in the process of installing smoke detectors in the sleeping rooms and agreed the staff sleeping room battery operated smoke detector was out of date.	K S300	Residential CRF, Inc. has contacted Koorsen to install smoke alarms in all client and staff sleeping rooms. Koorsen has been to the home for initial estimates. The administrator has approved the installation and it will be completed in a timely manner. Supervisor will insure that the installation is completed. Any existing battery operated smoke alarms will be removed. Staff will monitor operation during monthly drills and report immediately to supervisor if alarm system is not functioning properly, and corrective action will be taken. . Responsible: Supervisor, Administrative staff	03/10/2021

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	This finding was reviewed with the Administrator at the exit conference.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of	K S345	The Koorsen inspection and test reports from annual/semi-annual inspections will be made available at future Life Safety reviews. Supervisor will assure that inspections are completed as required and that the information is reflected on the report record. Responsible: Supervisor	03/10/2021

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	14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance shall be measured and recorded. Changes from acceptance test shall be investigated. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review the fire alarm system inspection contractor's "Inspection & Test Report" documentation with the Administrator during record review from 1:10 p.m. to 2:40 p.m. on 02/08/21, one heat detector in the facility was visually inspected 10/09/20 during the most recent twelve month period. The location of the heat detector was in the attic. Based on interview at the time of record review, the Administrator agreed annual testing and semiannual visual inspection documentation for attic heat detector and testing documentation for the attic heat detector within the most recent twelve month period was not available for review. Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, it could not be determined if the attic had heat detection due to the step ladder which was provided was not high enough to provide			

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	attic access. This finding was reviewed with the Administrator at the exit conference.			
K S347 Bldg. 01	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas.			

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	33.2.3.4.3. Based on observation and interview, 3 of 3 client sleeping rooms and 1 of 1 staff sleeping rooms were not provided with an approved smoke alarm in accordance with LSC 9.6.2.10. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, three client sleeping rooms each did not have a smoke alarm installed in the room. The staff sleeping room on the west side of the building had a wall mounted battery operated smoke detector installed above the corridor door in the room but the smoke detector was out of date. Manufacturer's information affixed to the back of the Fire Sentry Model 0914 smoke detector indicated it was manufactured May 16, 2007 and to "replace the detector after 10 years". Based on interview at the time of the observations, the Administrator stated the facility was in the process of installing smoke detectors in the client sleeping rooms and agreed each of the client sleeping rooms was not provided with a smoke alarm and the staff sleeping room battery operated smoke detector was out of date. This finding was reviewed with the Administrator at the exit conference.	K S347	Residential CRF, Inc. has contacted Koorsen to install smoke alarms in all client and staff sleeping rooms. Koorsen has been to the home for initial estimates. The administrator has approved the installation and it will be completed in a timely manner. Supervisor will insure that the installation is completed. Any existing battery operated smoke alarms will be removed. Staff will monitor operation during monthly drills and report immediately to supervisor if alarm system is not functioning properly, and corrective action will be taken. . Responsible: Supervisor, Administrative staff	03/10/2021
K S362 Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following:			

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	* Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6			

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RESIDENTIAL CRF INC	6155 W 800 N FOUNTAINTOWN, IN 46130

(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
	Based on observation and interview, the facility failed to ensure corridor walls in 2 of 2 smoke compartments were smoke resistant. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the following was noted: a. a four foot tall by ten inch wide hole was noted in the wall behind the water softener in the laundry. b. a two and and a half foot square hole was noted in the wall by the furnace in the laundry. c. a one foot by six hole hole was noted in the wall behind the washing machine in the laundry. d. a four inch square hole was noted in the wall above the washing machine in the laundry. e. a four inch square hole was noted in the wall in the pantry. Based on interview at the time of the observations, the Administrator agreed the openings in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Administrator at the exit conference.	K S362	The furnace room/laundry room walls will be repaired of holes and openings to ensure the corridor walls are smoke resistant. The hole in the pantry wall will also be repaired to also ensure the corridor walls are smoke resistant. Supervisor will ensure that walls remain in good repair and that house staff immediately report any further holes to maintenance immediately to prevent this deficient practice from recurring. Responsible: Maintenance, House Staff, Supervisor	03/10/2021
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G256	A. BUILDING 01 B. WING	02/08/2021

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	3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 client bedrooms had no impediment to closing and latched into the door frame. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the corridor door to the northeast bedroom was equipped with a self closing device to close the door and latch the door into the door frame but the door failed to latch into the door frame when tested to close multiple times. The latching mechanism failed to protrude into the latching plate. Based on interview at the time of the observations, the Administrator agreed the aforementioned corridor door failed to self close and latch into the door frame when tested to close multiple times. This finding was reviewed with the Administrator at the exit conference.	K S363	The corridor door latch to the northeast bedroom will be repaired to allow the door to latch completely into the door frame. Supervisor and house staff will check monthly to ensure that the doors latch completely, and if not, report immediately to maintenance for repairs. Responsible: Supervisor, Maintenance, House Staff	03/10/2021
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	15G256	A. BUILDING 01 B. WING	02/08/2021

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	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of 2 bathrooms were properly wired and grounded in accordance with NFPA 70. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection	K S511	The receptacles in the wall mounted outlet box in the west bathroom by the sink will be replaced with an appropriate GFI receptacle. The wiring to the receptacles will also be checked to ensure the receptacle is properly grounded to prevent a safety hazard condition. The supervisor will check outlets during monthly QA inspections to ensure that all electrical outlets/devices are safe. House staff will report any unsafe condition immediately to supervisor/maintenance and cease to use said device/ outlet until it is repaired. Responsible: Maintenance, Supervisor, House Staff	03/10/2021

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	to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect one client and staff. Findings include: Based on observations with the Administrator during a tour of the facility from 2:40 p.m. to 3:20 p.m. on 02/08/21, the electrical receptacles in the wall mounted outlet box by the sink in the west bathroom were found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. In addition, the receptacles did not "trip" when tested to trip with the tester. Based on interview at the time of the observations, the Administrator agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Administrator at the exit conference.			