STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING -- B. WING	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 483.73. Survey Date: 06/19/24 Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 At this Emergency Preparedness survey, Salem Crossing was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 92 certified beds and had a census of 81 at the time of this visit. Quality Review completed on 06/25/24	E 0000	Please find the enclosed plan of correction for the survey ending June 19, 2024. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/19/2024	K 0000	Please find the enclosed plan of correction for the survey ending June 19, 2024. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Thompson	Executive Director	07/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 At this Life Safety Code survey, Salem Crossing was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas open to the corridor. The facility has battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 92 and had a census of 81 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility storage services were sprinklered. Quality Review completed on 06/25/24		alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance; feel free to contact me with any questions.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 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 maintain latching hardware on 1 of 1 200	K 0100	1. No residents were harmed. 200 hall smoke doors were	07/03/2024

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	smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff, at leaast 15 residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/19/2024 between 12:00 PM and 2:00 PM with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, the 200 hall smoke doors did not latch into the frame. Based on interview at the time of observation, the Executive Director, Maintenance Director, and Regional Maintenance Supervisor agreed the aforementioned smoke doors did not latch into the frame. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		repaired and are latching into the frame. 2. All residents have the potential to be affected. All other smoke doors were inspected by Maintenance Director and are latching appropriately. 3. Life Safety Code Standard for K100 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect all smoke doors during daily walk thru to ensure they are latching appropriately. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 1 exterior gate from the 400 hall exit fenced-in area, swung in the direction of egress travel. LSC 7.2.1.4.2 states door leaves required to be of the side-hinged or pivoted-swinging type shall swing in the direction	K 0227	1. No residents were harmed. 400 hall emergency exit gate corrected to swing in the direction of egress to the sidewalk outside the gate. 2. All residents have the potential	07/03/2024

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	of egress travel. This deficient practice could affect staff, at least 10 residents, and visitors while exiting this area through the gate. Findings include: Based on observation on 06/19/2024 between 12:00 PM and 2:00 PM during a tour of the facility with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, the 400 hall emergency exit gate swung into the fenced in area instead of swinging in the direction of egress to the sidewalk outside the gate. Based on interview at the time of observation, the Maintenance Director and Regional Maintenance Director reported being told by the fire marshall the gate was supposed to swing into the fenced area. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		to be affected. No other emergency exit gates to inspect. 3. Life Safety Code Standard for K227 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect emergency exit gate monthly to swinging in the direction of egress. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Human Resources offices near the memory care unit which was over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff, visitors, and at least 10 residents in this smoke compartment. Findings include: Based on observations on 06/19/2024 between 12:00 PM and 2:00 PM with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, the door to the human resources office near the memory care unit had a significant amount of combustible materials, including bookcases filled with paper, and the door was not equipped with a self-closing mechanism. Based on	K 0321	1 No residents were harmed. Human Resources door was installed with a self-closing mechanism. 2 All residents have the potential to be affected. All other rooms were inspected by Maintenance Director to ensure rooms over 50 square feet were used for storage with no further areas of concern noted. 3 Life Safety Code Standard for K321 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect areas with hazardous materials monthly to ensure self-closing mechanism in place and functioning properly.	07/03/2024

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	interview at the time of the observation, the Executive Director, Maintenance Director, and Regional Maintenance Supervisor agreed the office had a significant amount of combustible materials and no self-closing mechanism. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		4 Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 physical therapy closets in accordance with NFPA 13, Standard for the Installation of Sprinkler	K 0351	1. No residents were harmed. Escutcheon replaced in physical therapy closet. 2. All residents have the	07/03/2024

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	Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 10 residents in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/19/2024 between 12:00 PM and 2:00 PM with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, 1 of 1 escutcheons was missing from the sprinkler head in the physical therapy closet. Based on interview at the time of the observation, the Maintenance Director agreed the physical therapy closet was missing an escutcheon. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		potential to be affected. All sprinkler heads were checked by Maintenance Director with no further areas of concern noted. 3. Life Safety Code Standard for K351 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect escutcheons during daily walk thru to ensure all are in place. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
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 ensure 1 of 1 fire extinguishers in the beauty shop was inspected on a monthly basis. 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	K 0355	1 1.No residents were harmed. Fire extinguisher has been inspected and monthly tag placed on extinguisher by IEI contractor. 2. All residents have the potential to be affected. All other	07/03/2024

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	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. 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 affect at least 5 residents, staff, and visitors to those smoke compartments. Findings include: Based on observation during a tour of the facility on 06/19/2024 between 12:00 PM and 2:00 PM with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor the monthly		fire extinguishers were inspected by Maintenance Director to ensure monthly tags were present with no further areas of concern noted. 3. Life Safety Code Standard for K355 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect fire extinguishers during daily walk thru to ensure no issues and monthly tags are present. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	

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	inspection tag on the fire extinguisher located in the beauty shop was missing and no documentation regarding monthly inspections was available for review. Based on interview at the time of observation, the Maintenance Director agreed there was no documentation available for the monthly inspections of the aforementioned fire extinguisher. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 1 doors to the 300 hall copy room door would close completely and latch into the door frame without issue. This deficient practice could affect staff, visitors, and at least 5 residents in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/19/2024 between 12:00 PM and 2:00 PM with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, the door to the 300 hall copy room area was able to be closed, however the frame shifted during closing at the top left corner of the door assembly revealing the top of the frame were not connected to the sides and it could not be assured the door was constructed to resist the passage of smoke. Based on interview at the time of observation, the Executive Director, Maintenance Director, and Regional Maintenance Supervisor agreed the door	K 0363	1. No residents were harmed. The door to the 300 hall copy room was corrected. 2. All residents have the potential to be affected. All doors were checked by Maintenance Director to ensure doors closed completely and latched into door frame with no further areas of concern noted. 3. Life Safety Code Standard for K363 reviewed with Maintenance Director by 7-1-24 by Executive Director (See Attachment A). Maintenance Director will inspect corridor doors during daily walk thru. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months	07/03/2024

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	frame was not connected on the top and sides. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
K 0372 SS=E 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 through 1 of 1 400 hall smoke barrier walls was 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 staff, at least 10 residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/19/2024 between 12:00 PM and 2:00 PM with	K 0372	1. No residents were harmed. Penetration located on the smoke barrier wall near the 400 hall has been corrected. 2. All residents have the potential to be affected. Maintenance Director inspected all other smoke barrier walls to ensure no other penetrations were present with no further areas of concern noted. 3. Life Safety Code Standard for K372 reviewed with Maintenance Director by 7-1-24 by Executive Director (See	07/03/2024

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	the Executive Director, Maintenance Director, and Regional Maintenance Supervisor, a 2 inch by 3 inch penetration was located on 1 side of the smoke barrier wall near the 400 hall. Based on interview at the time of observation, the Maintenance Director stated the penetration was likely due to work having been done in the area and provided the measurements for the penetration. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)		Attachment A). Maintenance Director will inspect areas during monthly walk thru and correct as needed. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the 300 hall pantry near the microwave were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities 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	K 0511	1. No residents were harmed. Electrical receptacle in the 300 pantry near the microwave was replaced. 2. All residents have the potential to be affected. All other electrical receptacles were inspected by Maintenance Director with no further areas of concern noted. 3. Life Safety Code Standard for K511 reviewed with Maintenance Director by 7-1-24 by Executive Director (See	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 01 B. WING	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

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	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 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 staff and at least 5 residents on the 300 hall.. Findings include: Based on observations with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor during a tour of the facility from 12:00 PM to 2:00 PM on 06/19/2024, 1 of 1 electrical receptacles in the 300 pantry near		Attachment A). Maintenance Director will inspect areas during monthly walk thru and correct as needed. Staff have been educated by Maintenance Director to report concerns of electrical receptors to the Maintenance Director immediately. 4. Maintenance Director or designee will complete Preventative Maintenance Audit (See Attachment B) weekly times 4 weeks, monthly times 6 months and then quarterly times 2 quarters. Any issues found during inspection will be addressed in the monthly QAPI meeting with follow-up as necessary.	

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	the microwave were found to have an open ground when tested with an Etcon UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned receptacle had an open ground when tested. This finding was reviewed with the Executive Director, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b)			