STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155508	A. BUILDING -- B. WING	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

(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: 02/12/25 Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 At this Emergency Preparedness survey, Transcendent Healthcare of Boonville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 102 certified beds. At the time of the survey, the census was 60. Quality Review completed on 02/18/25	E 0000	By submitting the enclosed materials, 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 requests the plan of correction be considered our allegation of compliance effective March 14, 2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on February 12, 2025.	
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: 02/12/25 Facility Number: 000451 Provider Number: 155508 AIM Number: 100266240 At this Life Safety Code survey, Transcendent	K 0000	By submitting the enclosed materials, 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 requests the plan of correction be considered our allegation of compliance effective March 14,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin L McCarty	Executive Director	03/02/2025

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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	Healthcare of Boonville was found not 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 with a basement 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 102 and had a census of 60 at the time of this survey. All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except two detached structures consisting of a garage used as a maintenance shop and maintenance storage, and a small cinder block shed used for facility storage and lawnmower storage. Quality Review completed on 02/18/25		2025 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on February 12, 2025.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 locked exit doors was readily and easily accessible for residents, staff, and visitors. This deficient practice could affect up to 10 residents, as well as staff and visitors. Findings include: Based on observations on 02/12/25 between 2:30	K 0222	K 222 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, ten residents, staff and visitors have the potential to be affected by this deficient practice. The northwest corridor	03/14/2025

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TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the northwest corridor exit door to the outside required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force, especially at the bottom, to open. Based on interview at the time of observation, the Maintenance Director acknowledged the exit door required heavy force at the bottom to open. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		exit door has now been adjusted by the maintenance staff and opens smoothing upon the entering of the code to the keypad. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide inspection of all corridor exit doors has now been completed and all doors open smoothly upon entering the code to the keypad. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on their responsibility to ensure that all corridor exit doors function properly and that egress can be smoothly obtained after entering the code to the keypad. The maintenance staff was also re-educated on their responsibility to check the proper functioning of all corridor exit doors as part of their preventative maintenance program and to document their findings. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that corridor door inspections are being conducted	

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			as part of the facility preventative maintenance program. The tool will monitor to ensure that each corridor door is functioning properly and egress is obtained smoothly upon entering the key pad code. This tool will be completed by the Maintenance Supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be submitted to the Executive Director to determine if any additional action is warranted.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation, and interview; the facility failed to ensure there was documentation for the testing of 5 of 5 battery backup lights that were tested annually for 90 minutes during the past 12 months to ensure the lights would provide lighting during periods of power outages. 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 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, as well as staff and visitors in the	K 0291	K 291 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All five battery backup lights have now been testing for 90 minutes. This testing has been documented and meets the regulatory requirement. The annual 90-minute testing has been documented in the facility's preventative maintenance manual for inspection by the authorities. Annual 90-minute testing of the battery backup lights will continue	03/14/2025

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	facility. Findings include: Based on record review on 02/12/25 between 10:15 a.m. and 2:30 p.m. with the Maintenance Director and Maintenance Assistant present, the facility did have a preventative maintenance (PM) report that the five battery powered emergency lights throughout the facility were tested monthly for 30 seconds during the past 12 month period. However, there was no documentation available to show the five battery powered emergency lights were tested annually for 90 minutes during the past 12 month period. The most recent 90 minutes annual test was dated 10/15/23. Based on an interview at the time of record review, this was confirmed by the Maintenance Director. During a tour of the facility with the Maintenance Director and Maintenance Assistant between 2:30 p.m. and 5:45 p.m., the facility was equipped with five emergency battery powered light units located throughout the facility. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		to be conducted in accordance with the regulations and the findings of these testing's recorded in the preventative maintenance manual. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All five battery backup lights have now been testing for 90 minutes. This testing has been documented and meets the regulatory requirement. The annual 90-minute testing has been documented in the facility's preventative maintenance manual for inspection by the authorities. Annual 90-minute testing of the battery backup lights will continue to be conducted in accordance with the regulations and the findings of these testing's recorded in the preventative maintenance manual. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to the annual required testing of all battery backup lights. The staff was re-educated on their responsibility to ensure that testing of all battery backup lights has been conducted and the findings documented at least	

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			annually in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the documentation of the annual 90-minutes testing of all battery backup lights will now be submitted to the Executive Director annually to ensure that the testing has been conducted and to determine if any additional action is warranted.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as a Medical Supply storage room door or emergency supply storage room door, was provided with a self closing device, or a door that was smoke resistant. This deficient practice could at least 20 residents and staff. Findings include: Based on observations on 02/12/25 between 2:30 p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the following was noted: a. The Medical Supply storage room corridor door was locked, however, it was not provided with a self closing device. The room was over 50 square feet in size and stored over 30 cardboard boxes full of supplies and several shelves with other combustible items, such as paper, plastic, and cardboard boxes. b. The 7 Day Emergency Supply Room corridor door was provided with a self closing device,	K 0321	K 321 *a.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, 20 residents and staff have the potential to be affected by this deficient practice. A self-closing device has now been placed on the medical supply storage room door for automatic closure and is functioning properly. *b.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, 20 residents and staff have the potential to be affected by this deficient practice. The corridor door to the 7 day	03/14/2025

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	however, there was a one half inch gap at the top of the door which made this door not smoke resistant. This room was over 50 square feet in size and stored over 20 cardboard boxes full of food supplies, and several shelves with other combustible items, such as paper and plastic containers. Based on interview at the time of each observation, the Maintenance Director and Maintenance Assistant acknowledged the lack of a self closing device on the Medical Supply room door and the one half inch gap at the top of the 7 Day Emergency Supply Room door. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		emergency supply room has now been adjusted by the maintenance staff and there is no longer any gap of the door into the door frame. The door fits securely into the door frame with no gaps to ensure smoke resistance. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide inspection has now been completed of all 10 hazardous area doors. All doors are equipped with an automatic closure which functions properly and all doors fit securely in the door frames with no gaps to ensure that they are smoke resistant. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to hazardous area closures. The staff has been re-educated on their responsibility to ensure that these doors remain smoke resistant (no gaps) and contain the proper functioning automatic door closure devices. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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			developed and implemented to monitor the condition and functioning of all hazardous area doors. This tool will monitor to ensure that the doors close securely into the door frames with no gaps and that they contain an automatic door closure device that is functioning properly. This tool will be completed by the Maintenance Supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be submitted to the Executive Director to determine if any additional action is warranted.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish in 1 of 9 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes	K 0331	K 331 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, 20 residents and staff have the potential to be affected by this deficient practice. The 2 foot by 2 foot plywood attic access panel in the ceiling of the maintenance work space, which is located in a small room in the northwest corridor and opens into the corridor now has an interior finish with a material that has a flame spread rating of Class A or Class B.	03/14/2025

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	any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect up to 20 residents and staff. Findings include: Based on observations on 02/12/25 between 2:30 p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, there was a two foot by two foot plywood attic access panel in the ceiling of the Maintenance Work Space area, which was a small room in the northwest corridor and open to the corridor. This was acknowledged by the Maintenance Director and Maintenance Assistant at the time of observation, furthermore, the Maintenance Director indicated the plywood attic access panel did not have a flame spread rating as far as she knew. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide inspection of all interior finishes of all nine smoke compartments has been conducted to ensure that all interior finishes are covered with a flame spread rating of Class A or Class B. No other areas of concern were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on the regulation related to interior wall and ceiling finishes. The staff was re-educated on the requirement that all interior wall and ceiling surface finishes must be covered with a material that has a flame spread rating of Class A or Class B. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will now submit a copy of the flame spread rating documentation of all interior finish materials utilized in any of the nine smoke compartments of the facility to the Executive Director for review. The Executive Director will review the documentation to ensure that the required Class A or Class B flame	

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			spread rating is being utilized in the facility's smoke compartments.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would close and latch to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 02/12/25 between 2:30 p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the set of smoke barrier/fire barrier doors leading into the southwest corridor did not close completely and latch when tested several times. These doors were equipped with latching hardware. There remained a one half inch gap between the doors when closed to their fullest. This was acknowledged by the Maintenance Director and Maintenance Assistant at the time of observation. The Maintenance Assistant worked on this set of smoke/fire doors at the time of observation, and was unable to make the doors close completely every time they were tested. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility	K 0374	K 374 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, at least 20 residents, staff and visitors have the potential to be affected by this deficient practice. The smoke barrier/fire barrier door located on the southwest corridor has now been adjusted by the maintenance staff. The door now closes and latches completely when tested. The smoke barrier/fire barrier doors will continue to be checked by the maintenance staff to ensure their continued proper closure and functioning. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All smoke barrier/fire barrier doors have now been inspected by the maintenance staff. All smoke barrier/fire barrier doors are now closing and latching completely when released.	03/14/2025

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	during the exit conference. 3.1-19(b)		*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all maintenance staff on their responsibility to ensue that all smoke barrier/fire barrier doors are checked for proper functioning in accordance with the regulation. The staff was re-educated on their responsibility to document these door inspections as part of the facility's preventative maintenance program and in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the proper functioning of smoke barrier/fire barrier doors. This tool will monitor to ensure that the doors close securely and latch completely upon release. This tool will be completed by the Maintenance Supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be submitted to the Executive Director to determine if any additional action is warranted.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility	K 0741	K 741	03/14/2025

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TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were allowed to be smoked by residents and staff. This deficient practice could affect up to 20 residents and staff. Findings include: Based on observations on 02/12/25 between 2:30 p.m. and 5:45 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the Courtyard outside the main dining room, which is the designated smoking area, had hundreds of cigarette butts scattered on the ground, along with two small metal cans and one styrofoam cup on a table, full of cigarette butts. Furthermore, there were several cigarette butts in a large plastic trash bag along with paper trash and either yard waste or a bird's nest. Based on interview at the time of observation, the Maintenance Director and Maintenance Assistant acknowledged the issues with the cigarette butts within the Courtyard smoking area, and further said, there are about 20 residents who use the Courtyard to smoke. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, approximately twenty residents and staff have the potential to be affected by this deficient practice. A deep cleaning of the smoking area has now been conducted. All cigarette butts have now been placed in the appropriate fire-retardant container and there are no cigarette butts on the ground or floor surface. The smoking area will continue to be supervised by facility staff who will ensure that all cigarette butts are properly disposed of in the proper designated containers. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents who smoke and all staff have the potential to be affected by this deficient practice. All cigarette butts have now been placed in the appropriate fire-retardant container and there are no cigarette butts on the ground or floor surface. The smoking area will continue to be supervised by facility staff who will ensure that all cigarette butts are properly disposed of in the proper designated containers. *The measures that have been put into place to ensure that the deficient practice does not recur is*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 01 B. WING	02/12/2025

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			that a mandatory in-service has been conducted for all staff on the facility smoking policy and their responsibilities to ensure that the smoking area is kept clean and that all cigarette butts are to be discarded in the appropriate fire-retardant containers. The staff was also reminded of their responsibility to supervisor all resident smokers and to remind the smokers of the proper manner to dispose of their cigarette butts. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the condition of the smoking area to ensure it remains clean and that all cigarette butts are disposed of in the fire-retardant containers. This tool will be completed by Social Services and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be submitted to the Executive Director to determine if any additional action is warranted.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99	K 0921	K 921 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no	03/14/2025

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	2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 02/12/25 between 10:15 a.m. and 2:30 p.m. with the Maintenance Director and Maintenance Assistant present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items as of yet. Based on observation between 2:30 p.m. to 5:45		specific residents were identified during the survey, all residents and staff that utilizes or operate portable patient care related electrical equipment have the potential to be affected by this deficient practice. All new and or recently repaired portable patient care related electrical equipment is now being inspected by the maintenance staff to ensure resident safety prior to being place into service. A record of these inspections will be documented in the facility's preventative maintenance manual. This will be an on-going process. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff that utilize or operate any portable patient care related electrical equipment have the potential to be affected by this deficient practice. All new and or recently repaired portable patient care related electrical equipment is now being inspected by the maintenance staff to ensure resident safety prior to being place into service. A record of these inspections will be documented in the facility's preventative maintenance manual. This will be an on-going process. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	

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	p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator, Maintenance Director, and owner of the facility during the exit conference. 3.1-19(b)		been provided for all maintenance staff on their responsibility to ensure that all new and/or repaired portable patient care related electrical equipment has been inspected by them prior to being placed into service. These inspections shall be documented in the facility's preventative maintenance manual for review. The maintenance staff was also advised that they were required to attend an annual in-service on the proper maintenance of and inspections of all portable patient care related electrical equipment utilized in the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will now submit a copy of the facility's PCREE report to the Executive Director monthly for their review and any additional recommendations that may be warranted. This will be a monthly on-going process.	