

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

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2012
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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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(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
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F 000 INITIAL COMMENTS

F 000

A standard health survey was conducted from 05/22/12 through 05/24/12 and a Life Safety Code survey was conducted on 05/23/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law.

The facility alleges compliance as of 6/30/2012.

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

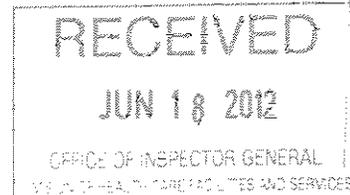
F431 Drug Records Label/Store Drugs & Biological

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

Nurses were re-educated on May 23rd, regarding signing off on the MARS when giving medication. (See attachment A.) Education was completed by MDS nurse. An audit was completed of other resident's MARs during monthly change over for June to ensure that no other residents were affected.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6-13-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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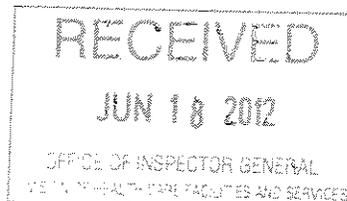
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F 431	<p>Continued From page 1</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined, the facility failed to develop a policy and procedure to monitor the disposition of controlled medications/substances in order to periodically reconcile the controlled medication/substance sign off pharmacy form with the Medication Administration Record (MAR). In addition, Residents #4 had a controlled medication/substance signed off on the pharmacy record but, the medication/substance was not signed off on the MAR.</p> <p>The findings include:</p> <p>1. Observations at the nursing station with the DON and ADON, on 05/24/12 at 2:30 PM, revealed empty medication blister packages visible through the slot of the paper shredding box. The DON was asked if this was the normal way staff disposed of empty medication blister packages? The response by the ADON was, yes.</p> <p>The ADON was asked at this time if the facility had a policy for controlled medications/substances. Her response was, no. The facility did not have a policy to address the disposal of blister medication packages when they are empty. In addition, the facility had no policy to reconcile controlled</p>	F 431	<p>The facility developed a policy on 5/24/2012 regarding medications/substances. (See attachment B). The Medical Director reviews all new facility policies as part the QA process policy was reviewed by Medical Director at May QA meeting 5/30/2012. The policy includes the disposal of blister medications packages when empty. The policy also includes reconciling controlled medications / substances. The policy also includes documentation of medications on the MAR and Controlled Drug Record.</p> <p>All nurses and KMA's will be in-serviced on this policy on 6/18/2012 by the DON and or ADON. This new policy is also part of orientation for all new nurse's and KMA's. (See attachment C).</p> <p>Resident #4 remains in the facility and resident's pain is managed and controlled according to physician orders. . Nurses were re-educated at the June 18th in-service to start a new MAR if sheet is full before</p>	
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F 431 Continued From page 2
medications/substances.

Interview with the pharmacy representative, on 05/24/12 at 4:00 PM, revealed the pharmacy had a policy for ordering and returning controlled medications to pharmacy. The pharmacy had no policy to monitor the reconciliation of pharmacy records with the MAR.

Review of the Narcotic Shift Count/Glucometer Quality Check Verification form revealed, on 05/18/12 on second and third shift; on 05/20/12 on first shift, there were no check marks to indicate the narcotic count was correct.

Interview with the DON, on 05/23/12 at 9:10 AM, revealed the facility had no mechanism in place to ensure medications were administered as the physician ordered. She stated, it would be a good idea to randomly monitor the amount of a medication/substance left against the MAR.

2. Interview with the ADON for the skilled Unit, on 05/24/12 at 1:00 PM, revealed there were no specific policies in place regarding documentation of medications on the MAR and the Controlled Drug Record.

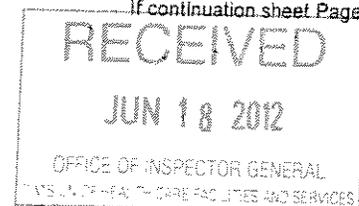
Review of Resident #4's clinical record revealed an admission date of 04/05/12, with an admission diagnosis of Fractured Hip with Rehabilitation. Review of the admission comprehensive assessment, dated 04/22/12, revealed the resident had frequent pain and required pain medication. Review of the resident's admission plan of care revealed the resident had a potential for alteration in comfort, related to the diagnosis

F 431

monthly change over. All nurses were counseled on documentation on the MAR by the ADON and the MDS nurse.

The DON and or ADON will do random weekly audits for two months after the June 18th in-service to monitor for compliance to the new policy regarding medications/substances. The sample size will be 100% on each household. The results of audit will be reported to the facilities Quality Assurance Committee. Further audits will be assigned at the discretion of the QA committee.

6/30/12



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F 431 Continued From page 3

of recent surgery to hip and therapy. Review of the admission physician's orders, dated 04/05/12, revealed the resident was to have Hydrocodone 6/325mg, 1 tablet every 6 hours for pain, and 2 tablets every 6 hours for pain, if severe.

Review of the Resident's Medication Administration Record revealed the Hydrocodone had been given to Resident #4, on 5/18, 5/19, and 5/22/12; Further review of the MAR revealed multiple entries of pain medication, which had been documented on the incorrect date, and revealed no more spaces on the MAR to document.

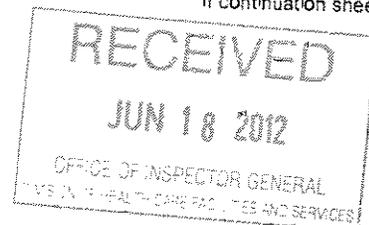
However, review of the Controlled Narcotic Drug record revealed the resident had also received the Hydrocodone pain medication, on 5/20/12 at 8:00 AM and 8:00 PM, and again, on 5/21 at 8:00 PM. In addition, the resident was also given two tablets, on 5/21/12 at 9:00 PM, however this was entered on the Narcotic sheet in the incorrect date. The date on the MAR was listed as 5/22/12 at 9:00 PM.

Observation of Resident #4, on 05/22/12 at 1:45 PM, and again, on 5/23/12 at 10:00 AM, revealed the resident in the Physical Therapy department participating in therapy.

Interview with Resident #4, on 05/22/12 at 4:30 PM, revealed the resident had a great deal of pain with his/her hip fracture since admission, and had been going to therapy daily.

Interview with the B Hall Unit Manager, on 05/23/12 at 11:00 AM, revealed the Nurse probably ran out of room on the MAR; however

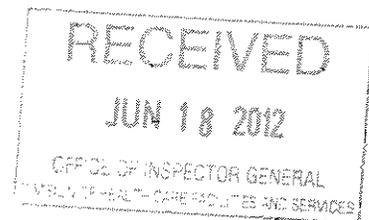
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F 431	Continued From page 4 stated this should have been documented in the MAR as well as the Narcotic sign out sheet. She also stated there should have been a new MAR started to document the medication. The Unit Manager stated Resident #4's pain was well controlled now and had not exhibited any facial expressions of being in pain.	F 431			



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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 02 PLAN APPROVAL: 04/06/2010 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURES: One (1) story, Type V (111) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system. The dry sprinkler system covers the exterior canopies. GENERATOR: Type tl generator, fuel source is diesel. A standard Life Safety Code survey was conducted on 05/23/12. Madonna Manor was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.	K 000	The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law. The facility alleges compliance as of 6/30/2012.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X8) DATE *6/11/12*

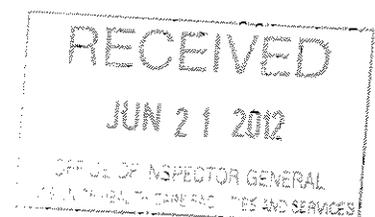
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JUN 21 2012
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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at an F level.	K 000			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panets in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds and the census was fifty-four (54) on the day of the survey.	K 025	K025 Smoke barriers in resident areas A, B, C and the common area D have all been re-inspected for breaches in the smoke barrier. Breaches have been properly sealed on both sides of the smoke barrier wall by the Facility Director. This work was completed on or before 6/15/2012. The Facility Maintenance Director will inspect the smoke barriers in resident areas A, B, C and the common area D quarterly as part of his rounds and immediately after any work is done in these areas to monitor for compliance.	6/30/12	



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K 025 Continued From page 2

K 025

The findings include:

Observations, on 05/23/12 between 1:45 PM and 2:15 PM, with the Facility Director revealed the three (3) fire resistant rated smoke barriers separating Resident Areas A, B and C from the Common Area D, had been penetrated by newly installed data lines above the ceilings. Further observations revealed the fire rated seatant initially applied during the original construction phase had failed. The spaces around the penetrations were not fitted with a material rated equal to the smoke barrier and could not resist the passage of smoke.

Interviews, on 05/23/12 between 1:45 PM and 2:15 PM, with the Facility Director revealed he was unaware of the penetrations in the smoke barriers and acknowledged the penetrations were a result of the newly installed data lines. It was his understanding that the Contractor installing the new data lines was required to properly seal the penetrations as part of their scope of work. He also acknowledged that the seatant initially applied during the original construction phase had failed since the Facility had been issued an Occupancy Permit and should be reapplied to maintain the integrity of the fire rated smoke barrier.

Reference: NFPA 101 (2000 Edition).

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar

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K 025 Continued From page 3
building service equipment that pass through floors and smoke barriers shall be protected as follows:
(a) The space between the penetrating item and the smoke barrier shall
1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.
(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall
1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall
1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

K 025

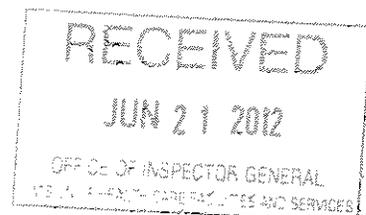
K 052 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to test the fire alarm

K 052

K052 Testing of the fire alarm system. Testing for the second quarter 2012 of the fire alarm system was completed on June 15th. By SimplexGrinnell (see attachment A). The Facility Maintenance Director will maintain a schedule of quarterly inspections and documentation to support those inspections. The calendar and inspections results will be turned into the facilities quality assurance committee.

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K 052 Continued From page 4

system quarterly in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty-four (54) on the day of the survey.

Findings include:

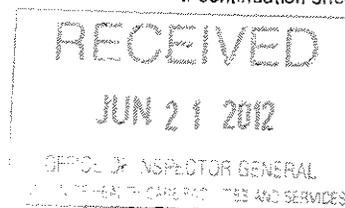
Record review of the Fire Alarm System, on 05/23/12 at 2:30 PM, with the Facility Director revealed the Company contracted by the Facility to maintain the Fire Alarm System had made numerous service runs to the Facility since its opening on July 1, 2011. The invoices for the service runs had been retained and were reviewed with the Facility Director; however, there was no documentation that quarterly inspections were performed for the first two (2) quarters of 2012 and the last two (2) quarters of 2011, in accordance with NFPA standards.

Interview, on 05/23/12 at 2:30 PM, with the Facility Director revealed it was his understanding that the Company contracted to maintain the Fire Alarm System had been performing the quarterly inspections. The invoices retained for service runs may have been mistaken for documentation of the required quarterly inspection reports.

Reference: NFPA 101 (2000 edition).

9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of

K 052



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K 052 Continued From page 5
NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.

K 052

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

K 062

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to have quarterly inspections and testing performed on the automatic sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty-four (54) on the day of the survey.

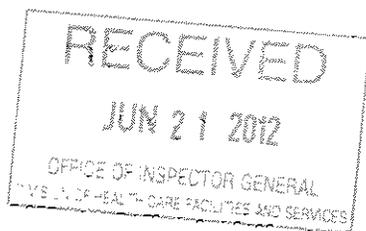
K062 Testing of the Automatic Sprinkler System
Testing for the second quarter 2012 Automatic Sprinkler System was completed on June 13th. By SimplexGrinnell (see attachment B) The Facility Maintenance Director will maintain a schedule of quarterly inspections and documentation to support those inspections. The calendar and inspections results will be turned into the facilities quality assurance committee.

The findings include:

Record review of the Automatic Sprinkler System, on 05/23/12 at 2:45 PM, with the Facility Director revealed the facility did not produce any evidence of quarterly inspections and testing being performed on the automatic sprinkler system.

Interview, on 05/23/12 at 2:45 PM, with the Facility Director revealed the Facility had contracted a company to maintain the automatic sprinkler system. It was his understanding that the sprinkler company would perform the

G/30/12



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 2011 B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2012
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K 062 Continued From page 6 inspections as required by NFPA standards.

Reference: NFPA 25 (1998 Edition).

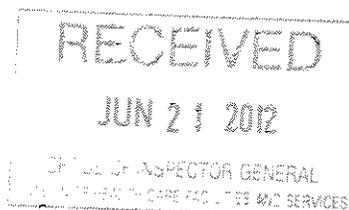
2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.

Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.

Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance

Item	Activity	Frequency	Reference
Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2
Control valves	Inspection	Weekly/monthly	Table 9-1
Alarm devices	Inspection	Quarterly	2-2.6
Gauges (wet pipe systems)	inspection	Monthly	2-2.4.1
Hydraulic nameplate	Inspection	Quarterly	2-2.7
Buildings	Inspection	Annually (prior to freezing weather)	2-2.5
Hanger/seismic bracing	Inspection	Annually	2-2.3
Pipe and fittings	Inspection	Annually	2-2.2
Sprinklers	Inspection	Annually	2-2.1.1
Spare sprinklers	Inspection	Annually	2-2.1.3
Fire department connections	Inspection	Table 9-1	
Valves (all types)	Inspection	Table 9-1	
Alarm devices	Test	Quarterly	2-3.3
Main drain	Test	Annually	Table 9-1
Antifreeze solution	Test	Annually	2-3.4

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K 062 Continued From page 7
Gauges Test 5 years 2-3.2
Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3
Sprinklers - fast response Test at 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2
Sprinklers Test at 50 years and every 10 years thereafter 2-3.1.1
Valves (all types) Maintenance Annually or as needed Table 9-1
Obstruction investigation Maintenance 5 years or as needed Chapter 10

K 073 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds and the census was fifty-four (54) on the day of the survey.

The findings include:

Observations, on 05/23/12 between 10:00 AM and 11:30 AM, with the Facility Director revealed hanging decorations mounted on the residents' room doors in various locations within Resident Areas A, B and C.

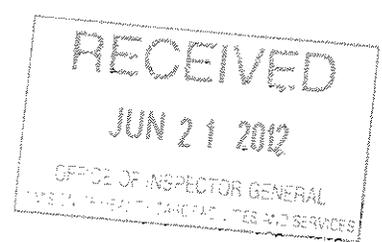
Interviews, on 05/23/12 between 10:00 AM

K 062

K073

All combustible decorations were removed from resident doors in resident areas A, B, & C.
A policy regarding decorations of highly flammable character was sent out to all current family members and has been added to the admission packet. See attachment C. Staff was in-serviced on 6/8/2012 by facility maintenance director that decorations of combustible nature are not to be hanging on resident doors, unless they have been treated with a flame retardant spray and tagged by maintenance. This policy will also be part of orientation for new employees. Facility Maintenance Director will monitor for compliance during weekly rounding. Families will also be reminded of the policy at care plan conference. The Maintenance Director will report results of weekly rounding to QA committee monthly.

6/30/12



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K 073 Continued From page 8
and 11:30 AM, with the Facility Director revealed he was unaware hanging decorations were required to be treated with a flame-retardant spray; and to have a written policy for documentation of wreaths and other decorations were being properly treated.

Reference: NFPA 101 (2000 Edition)

18.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.

Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately ten (10) residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty-four (54) on the day of the survey.

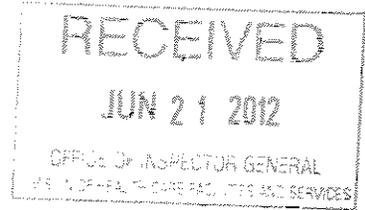
The findings include:

K 073

K 147 Electrical Wiring
The electrical outlet located in the physical therapy storage area has been changed from a standard electrical outlet to a Ground Fault Circuit Interrupter (GFCI) outlet. This work was completed on 5/25/2012. During weekly rounding the Facility Director will monitor medical equipment in wet areas for proper outlets in those areas. The Facility Maintenance Director checked all other outlets to ensure proper outlets we installed.

The Facility Maintenance Director will monitor that all equipment is plugged into only GFI breakers results of rounds will be reported to the facility monthly QA committee.

C/30/r



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K 147	<p>Continued From page 9</p> <p>Observation, on 05/23/12 at 2:00 PM, with the Facility Director revealed medical equipment (a Hydrocollator) located in the Physical Therapy Storage Room was plugged into a standard electrical outlet, instead of a Ground Fault Circuit Interrupter (GFCI) outlet as required in wet areas.</p> <p>Interview, on 05/15/12 at 7:57 AM, with the Maintenance Director revealed he was not aware of the requirement for the Hydrocollator (containing water) to be protected by plugging it into a (GFCI) outlet.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		

