

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

PRINTED: 12/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2012
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NAME OF PROVIDER OR SUPPLIER FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 000	INITIAL COMMENTS A standard health survey was initiated on 12/04/12 through 12/06/12 and a Life Safety Code survey was conducted on 12/04/12. Deficiencies were sited 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 000	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #7 received a comprehensive care plan for pain on December 6, 2012. Resident was assessed for pain by the FNP on December 17, 2012.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a comprehensive care plan to address	F 279	2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken; Audit of residents who receive pain medication will be conducted by the MDS nurses by January 11, 2013 to ensure they have a pain care plan. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does MDS nurses received 1:1 inservice by the DON on December 27, 2012 on the process of performing comprehensive care plans for resident's having triggering pain on the CAA's or receiving pain medication. DON/ADON/Unit Manager/SDC will audit weekly times four then monthly times eight that residents triggering for pain on the CAA's, or receiving pain medication are care planned for pain.	1/15/13

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicole Made</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/15/13</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that the 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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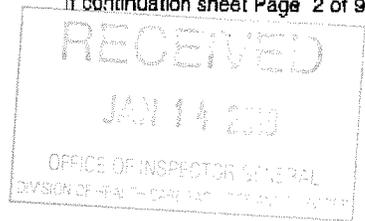
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F 279	<p>Continued From page 1</p> <p>pain for one (1) of fifteen (15) sampled residents, Resident seven (7).</p> <p>The Findings include:</p> <p>Review of the facility's care plan policy, dated 12/2010, revealed the facility developed the comprehensive care plan based on needs, concerns, or problems identified during the initial assessment, and supplementary information obtained through review of the physician's orders and the resident's history and physical.</p> <p>Review of the clinical record for Resident #7 revealed the facility admitted the resident on 10/30/12 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Pulmonary Hypertension, Diabetes, Sleep Apnea, Cellulitis, and a Wound Abscess. Review revealed, routine and as needed pain medications were ordered on admission (10/30/12) for Resident #7 by the physician. Review of the Care Area Assessment Summary (CAAS) within the Resident Assessment Inventory (RAI) revealed Resident #7 triggered for pain. Review of Resident #7's comprehensive care plan revealed there was not a care plan for pain.</p> <p>Interview, on 12/05/12 at 10:35 AM, with Licensed Practical Nurse (LPN) #1 revealed Resident #7 took his/her routine pain medication every four (4) hours for pain associated with an abscessed wound and cellulitis in his/her legs. LPN #1 stated she assessed Resident #7's pain using a pain assessment tool prior to administer the pain medication, and other interventions that were helpful for relieving Resident #7's pain included</p>	F 279	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The ADON/Unit Manager will report monthly times nine to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations. After nine months the PI committee, based on the analysis of the audit results will determine if the threshold was met and if future interventions are needed or if monitoring can be decreased.</p>	
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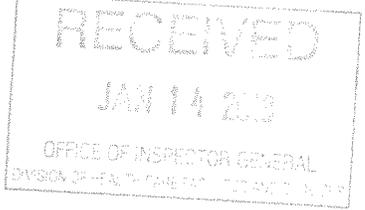
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F 279	<p>Continued From page 2 repositioning, and listening to soft music.</p> <p>Interview, on 12/06/12 at 1:50 PM, with the MDS nurses revealed every triggered area identified through the RAI process should be care planned, and the MDS nurses were ultimately responsible to ensure a complete comprehensive care plan was available to all staff responsible for Resident #7's care. The MDS nurses stated the care plan impacted the delivery of care because dally staff assignments were made based on the needs identified through the care plan process. If the care plan was incomplete, necessary areas of care would be missed.</p>	F 279	<p>F456-</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Hi/ Low Checks were performed on Glucometers by the ADON/ Unit Manager on 4 of 4 medication carts on December 6, 2012. All were within normal range.</p>	
F 456 SS=F	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of equipment log and review of manufactures recommendations, It was determined the facility failed to maintained Glucometer devises for four (4) of four (4) medication carts. The facillty failed to complete glucometer control testing for all machines used in the facillty as recommended from the manufacture.</p> <p>The findings include: Review of the Manufacture instructions for the Assure Platinum Glucometer, section B, revealed Quality checks should be used to check when</p>	F 456	<p>2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;</p> <p>Hi/Low Checks were performed on Glucometers by the ADON/ Unit Manager on 4 of 4 medication carts on December 6, 2012. All were within normal range.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and</p>	1/15/13



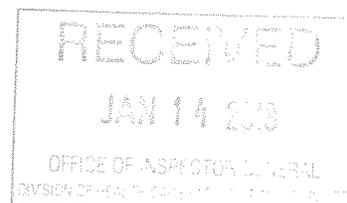
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F 456	<p>Continued From page 3</p> <p>testing the machine for the first time, when you open a new bottle of test strips, and whenever you suspect malfunction of the machine or test strips. Within the manual it included a control check flowsheet.</p> <p>Observation, on 12/06/12 at 8:50 AM, found no documentation of control testing for any of the Glucometers used in the facility.</p> <p>Interview with the Director of Nursing, on 12/06/12 at 8:55 AM, revealed she was unable to find any glucose control logs since May 2012.</p> <p>Interview with the A Unit Assistant Director of Nursing, unit on 12/06/12 at 9:00 AM, revealed she did not know the Glucometer had to have quality control checks.</p> <p>Interview with Licensed Practical Nurse #2, on 12/06/12 at 9:05 AM, revealed she worked on the Linker Unit. She stated she was told they were not required to do control testing on the machines. During review of the policy, she stated she was not aware the machines had to be checked with every bottle of new test strips.</p> <p>Interview with LPN #3, on 12/06/12 at 9:10 AM, revealed she thought the night shift checked the glucometer for quality control testing and was not aware they needed to be checked with each new bottle of strips.</p>	F 456	<p>Licensed Nurses will be inserviced on performing Hi/Low Quality Checks by January 11, 2013 by DON/ADON/SDC. Daily Hi/Low checks will be performed by nurses on glucometers in use. ADON/Unit Manager/ Weekend Supervisor/SDC will daily audit for compliance of Hi/Low checks on Glucometers for four weeks and then weekly times eight then monthly times six.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The ADON/Unit Manager/DON will report monthly times nine to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations. After nine months the PI committee, based on the analysis of the audit results will determine if the threshold was meet and if future interventions are needed or if monitoring can be decreased.</p>	
F 514 SS=B	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional</p>	F 514		1/15/13



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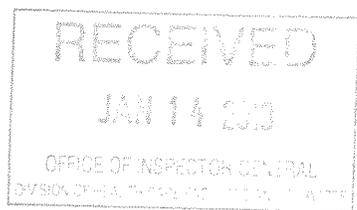
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F 514	<p>Continued From page 4</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure medical records were accurate for one (1) of fifteen (15) sampled residents, (#7), and one (1) of one (1) unsampled resident (A). Resident #7 and Unsampled Resident A had physician orders that were not transcribed correctly.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Administration-Physician Orders, Admission, effective 12/10, revealed admission orders will be obtained prior to or at the time of admission. If transfer orders are sent with the resident, the attending physician will be notified to verify the orders. The communication will be documented in the nurses notes.</p> <p>1. Observation of the medication pass, on 12/05/12 at 8:30 AM, revealed RN #1 administered two medications to unsampled Resident A.</p>	F 514	<p>F514-</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Unsampled Resident A's order for Miralax was transcribed to the MAR on December 5, 2012. On December 5, 2012 FNP was made aware of the Miralax not being transcribed to the MAR when ordered on December 3, 2012. ADON contacted MD of resident #7 on December 5, 2012 and received clarification of the orders for pain medication and transcribed these to the MAR. Resident # 7 had her pain assessed by the FNP on December 17, 2012.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action</p> <p>Residents who reside on A Wing's charts were audited by the ADON on December 5, 2012 to ensure orders written on December 3, 2012 were transcribed to the MAR. In house residents will have their orders for the month of December audited by the DON/ADON/Unit Manager/Nurse Consultant to ensure</p>	
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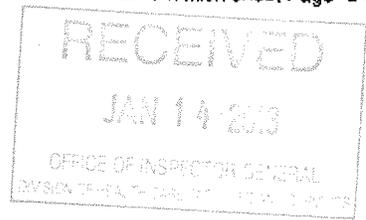
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F 514	<p>Continued From page 5</p> <p>Review of the medical record during the medication reconciliation for unsampled Resident A revealed an order for Miralax 17 Grams in 8 ounces of liquid daily, written on 12/03/12 at 5:00 PM. Review of the current medication administration record (MAR) on 12/05/12 revealed no order for Miralax documented on the MAR.</p> <p>Interview with Registered Nurse #1, on 12/05/12 at 9:00 AM, revealed she acknowledged there was not an order for Miralax on the MAR; however, it was written on 12/03/12. She stated it did not get carried over.</p> <p>Interview with the A Unit Assistant Director of Nursing (ADON), on 12/06/12 at 9:15 AM, revealed the nurses should be checking the charts at the change of shift every day to verify that any new orders had been put on the MAR and sent to the Pharmacy.</p> <p>Review of the 24 hour chart check form on Unsampled Resident A's chart revealed a chart check was completed on 12/03/12 and 12/05/12, but not on 12/04/12.</p> <p>Attempts to phone the RN, on 12/06/12 at 9:30 AM, who took the order on 12/03/12 were not returned.</p> <p>Interview with LPN #4, on 12/06/12 at 2:10 PM, revealed when a nurse received a new order, they transferred the order to the MAR, and faxed it to the pharmacy. She stated there were three copies of the order. The yellow copy went on the 24 hour report, the green copy went to the</p>	F 514	<p>transcriptions of the orders are accurate by January 11, 2013. Any issues will be corrected and addressed with MD or FNP.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not</p> <p>The nurses who had unsampled resident A on December 3, 2012 will be inserviced by the DON on the process of transcribing orders by January 11, 2013. The nurse who transcribed the order for resident #7 no longer works at the facility. Licensed nurses will be inserviced on process of transcribing orders by the DON/ADON/SDC by January 11, 2013. ADON/Unit Manager/Weekend Supervisor will daily audit orders to ensure they are transcribed correctly. Residents that are newly admitted to the facility or readmitted will daily have their orders checked by the ADON/Unit Manager/ Weekend Supervisor to ensure they are transcribed correctly.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p>	



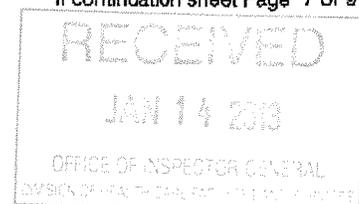
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F 514	<p>Continued From page 6</p> <p>Minimum Data Set (MDS) nurse, and the white copies went to medical records/ADON. She went on to say Medical records picked up the original copy the next morning and audited the MAR and Treatment Administration Record (TAR) to verify the orders had been written on the MAR and TAR.</p> <p>Interview with Medical Records #1, on 12/06/12 at 2:25 PM, revealed she recalled seeing the order for Unsampled Resident A and stated she had questioned the A Unit ADON. She stated she thought the ADON was taking care of the order for the Miralax.</p> <p>Interview with the A Unit ADON, on 12/06/12 at 2:40 PM, revealed she did get a copy of all the new orders and usually did go through the MAR and Treatment records to ensure the orders were transcribed. She stated she did not have a chance to go through the orders dated 12/03/12, because of the survey. She stated she did recall Medical Records #1 asked her about an order on Unsampled Resident A; however, it was not about the Miralax order, it was about a home medication.</p> <p>2. Review of the clinical record for Resident #7, revealed an order dated 10/30/12, for Lortab 7.5mg/325 mg to be given every four (4) hours for pain. Review of the Medication Administration Record (MAR) revealed on 10/30/12, the order for Lortab 7.5 mg/325 mg was transcribed onto the MAR as Lortab 7.5 mg/325 mg every 4 hours, p.r.n. (as needed basis). Further, the MAR revealed Lortab 7.5 mg/325 mg was given on a p.r.n. basis from 10/31/12 through 11/30/12.</p>	F 514	<p>The ADON/Unit Manager will report monthly times nine to the PI committee the audit findings. The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations. After nine months the PI committee, based on the analysis of the audit results will determine if the threshold was met and if future interventions are needed or if monitoring can be decreased.</p>	



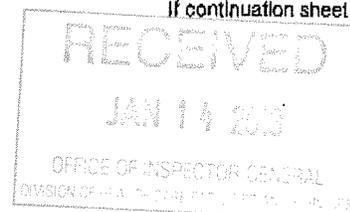
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F 514	<p>Continued From page 7</p> <p>Interview, on 12/06/12 at 10:20 AM, with Resident #7 revealed her pain had never been excessive, and the nursing staff had given her the Lortab when she asked for it, If it was time for her next dose. She was aware she had an as needed order for Tylenol, but didn't believe she had taken it very often.</p> <p>Interview, on 12/06/12 at 10:30 AM, with the A Unit ADON revealed she interpreted the order written on 10/30/12 as Lortab 7.5 mg/325 mg, every 4 hours, as a routine dose. Upon review of the MAR, the ADON stated the Lortab order was transcribed as a p.r.n. order. The ADON stated the nurse that admitted Resident #7 should have notified the attending physician to verify the transfer orders and obtain any new orders and clarification of orders as needed. Orders were not to be transcribed to the MAR or other treatment records until they had been verified by the physician. The ADON stated the evening shift nurses reviewed all new orders dally and verified the orders were accurately transcribed by signing and dating the 24 hour chart check sheet within the clinical record. The ADON stated there was no documentation on the chart check sheet in Resident #7's clinical record until 11/05/12. The ADON stated when she became aware of the discrepancy between the previous order and how it had been transcribed onto the MAR and administered from 10/31/12 to 11/30/12, she contacted Resident #7's physician, on 12/05/12 at 12:00 PM, to obtain clarification of the Lortab order, and placed the clarified order on the chart.</p> <p>Interview with the Director of Nursing, on 12/06/12 at 3:00 PM, regarding the problems with</p>	F 514		



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F 514	Continued From page 8 transcribing orders in which she indicated the facility did have checks and balances to ensure orders don't get missed; however, it was not working correctly.	F 514		

If continuation sheet Page 9 of 9

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JAN 14 2013

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DIVISION OF HEALTH-CARE REGULATION AND COMPLIANCE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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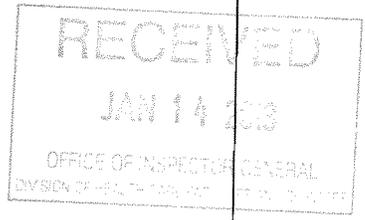
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0202 B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2012
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NAME OF PROVIDER OR SUPPLIER FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III protected.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators, 100KW and 80KW. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/04/12. Four Courts at Cherokee Park was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has eighty-four (84) certified beds and the census was sixty-one (61) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicole Meade LWH</i>	TITLE <i>x Administrator x</i>	(X6) DATE <i>1/11/13</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

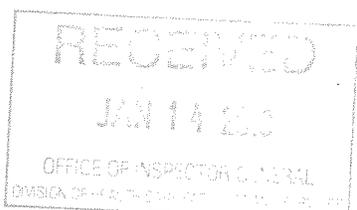
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000 K 029 SS=D	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments in the basement, residents, staff and visitors. The facility has eighty-four (84) certified beds and the census was sixty-one (61) on the day of the survey. The facility failed to ensure all doors in hazardous areas were equipped with self closing devices. The facility failed to ensure the staff was knowledgeable of the requirements for self closing devices in hazardous areas.</p>	K 000 K 029	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The door to the Storage Room within the Beauty/Barber Shop located in the basement had a self closing device attached on December 4, 2012 by the Maintenance Director.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken;</p> <p>Residents using the basement had the potential to be affected. Audit of doors in the facility was completed by Maintenance on December 11, 2012, for self closing devices.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and</p> <p>The Maintenance Director will receive inservice by the Administrator by January 11, 2013 on have self closing doors in hazardous areas. The maintenance department will audit doors in the facility weekly times four and then monthly times eight to ensure self closing devices are in place.</p>	1/15/13



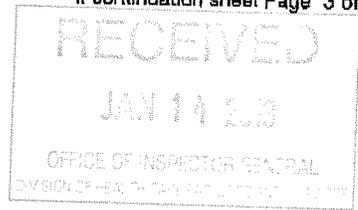
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K 029	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 12/04/12 at 10:07 AM, with the Maintenance Director revealed the door to the Storage Room within the Beauty/Barber Shop, located in the basement, did not have a self-closing device installed on the door.</p> <p>Interview, on 12/04/12 at 10:07 AM, with the Maintenance Director revealed he was not aware of the Storage Room being categorized as a hazardous storage room, and the requirement that the door be equipped with a self-closing device.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops 	K 029	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The Maintenance Director/Maintenance Assistant will report monthly times nine to the PI committee the audit findings.</p> <p>The PI committee will review and discuss the audit findings and make any necessary revisions or recommendations. After nine months the PI committee, based on the analysis of the audit results will determine if the threshold was met and if future interventions are needed or if monitoring can be decreased.</p>	



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K 029	Continued From page 3 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

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