Brinton Woods
Health & Rehabilitation Center
at Dupont Circle

February 20, 2017

Sharon Williams Lewis, DHR, RN-BC,CPM

Interim Senior Deputy Director

District of Columbia Department of Health

899 North Capitol Street, NE., 2nd Floor

Washington, DC 20002

Dear Ms. Lewis

Enclosed is our plan of correction which constitutes our written and credible allegation

Of compliance based on the deficiencies cited during our January 18, 2017 Life Safety.

At Brinton Woods Health & Rehabilitation Center at Dupont Circle, we are grateful to you for the professional guidance we received during the investigation. Again, thank you for helping us serve our seniors.

Sincerely,

Olayinka Oyekoya, 2/17/17

Administrator

2131 O Street NW • Washington, DC 20037 • Office 202-785-2577 • Fax 202-517-9103

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 000	INITIAL COMMENTS The following findings were identified during the Life Safety Code survey conducted January 18, 2017.	K 000		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: A. Based on observations during the Life Safety Code Inspection; it was determined that sprinklers, shaft surfaces and/or escutcheon rings were soiled with dust, paint or other debris which could potentially hamper the operation of sprinklers in the event of an emergency in 11 of 15 observations. These findings were observed in the presence of the Director of Maintenance. The findings include:	K 353	1 Dust was removed from sprinklers and escutcheon rings in 3 East Clean Linen Room, Rehab Department, 5 South Pantry Room, room 312 and room 413. Rusty sprinkler head and escutcheon ring in janitor closet closet located in the lobby was replaced with new sprinkler head and escutcheon ring. Paint on sprinkler heads and escutcheon rings in rooms 312, 118 and first floor supply closet were removed. Facility stand pipe caps will be Inspected by an outside vendor. 2 Director of Maintenance/designee	2/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	2/20/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 353	Continued From page 1 1. Dust and rust accumulation was observed on sprinkler head, shaft surfaces and escutcheon rings in eight (8) of 15 observations as follows: 3 East Clean Linen Room in one (1) of one (1) observation Rehabilitation Department in three (3) of four (4) observations 5 South Pantry Room in one (1) of two (2) observations Room 312 in one (1) of two (2) observations Room 413 in one (1) of one (1) observation Janitorial Closet located in the Lobby in one (1) of one (1) observation The findings were observed in the presence of the Director of Engineering between 2:00 PM and 4:05 PM on January 18, 2017. 2. Paint was observed on sprinkler heads and escutcheon rings in three (3) of 15 observations as follows: Toilet Room 312 in one (1) of one (1) observation Room 118 in one (1) of two (2) observations First Floor Supply Closet in in one (1) of one (1) observation The findings were observed in the presence of the Director of Engineering between 4:05 PM and 5:05 PM on January 18, 2017.	K 353	conducted an audit of sprinkler heads and escutcheon rings to ensure no dust, paint, or other debris that could potentially hamper the operation of sprinklers was present. Director of Maintenance / designee conducted an audit of stand pipe caps to ensure they are loosely maintained to ensure easy access by Fire Department in the event of an emergency. 3.Director of Maintenance/designee will in-service maintenance staff on ensuring there is no presence of dust, paint, or other debris on sprinkler heads and escutcheon rings that could potentially hamper the operation of sprinklers. Director of maintenance / designee will in-service maintenance staff to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 353	Continued From page 2 B. Based on observations during the Life Safety Code Inspection, it was determined that standpipe caps which are a part of the Automatic Sprinkler System were not maintained to allow easy access by the Fire Department in the event of an emergency in seven (7) of 10 observations. These findings were observed in the presence of the Maintenance Director. The findings include: Standpipe caps were not loosely maintained in 7 of 10 observations to ensure easy access by the Fire Department in the event of an emergency in the following areas. <u>Third Floor</u> 3 North Stairwell 3 West Stairwell 3 East Stairwell. <u>Second Floor</u> 2 East Stairwell 2 North Stairwell <u>First floor</u> 1 East Stairwell, 1 West Stairwell	K 353	ensure stand pipe caps are loosely maintained to ensure easy access by Fire Department in the event of an emergency. 4. Director of maintenance/designee will conduct audits of sprinkler heads and escutcheon rings to ensure no dust, paint, or other debris that could potentially hamper the operation of sprinklers is present. Director of maintenance / designee will conducted audits of stand pipe caps to ensure they are loosely maintained to ensure easy access by Fire Department in the event of an emergency. Director of Maintenance / designee will report audit findings to the QA committee monthly X 3 months to ensure compliance.	2/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 353	Continued From page 3 The observations were conducted in the presence of the Maintenance Director who acknowledged the findings between 3:15 PM and 4:35 PM on January 18, 2017.	K 353		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363	1.Entrance doors located near the end of unit 2 south, room 502, and room 516 have been ordered and are to be replaced by an outside vendor. Wedges and/or door stops improperly holding doors open were removed at the time of survey. 2. Director of Maintenance / designee conducted an audit of single and double swinging doors to ensure they closed and latched into frames and of doors in common areas to ensure they were not propped open with wedges. 3. Director of Maintenance / designee will educate facility staff on ensuring single and double swinging doors close and latch into frames and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW WASHINGTON, DC 20037**

(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
K 363	Continued From page 4 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that single and double swinging doors failed to close and latch into frames when tested and doors in common areas were propped open with wedges in five of six (6) of 15 observations. These findings were observed in the presence of the Maintenance Director The findings include: 1. The entrance door located near the end of Unit 2 South was damaged and failed to close when tested in one (1) of six (6) observations at 4:10 PM on January 18, 2017. 2. Doors located between the Dining Room and the Main Kitchen and in the Dietary Storage Room were improperly held open with wedges and/or door stops which would impede the doors from closing in the event of an emergency, in three (3) of three (3) observations at 2:15 PM on January 18, 2017. 3. Entrance doors to Rooms 502 North and 516 North failed to close and latch into frames when tested in two (2) of six (6) observations between 2:45 PM and 3:10 PM on January 18, 2016.	K 363	ensure doors in common areas are not propped open with wedges. Issues should be reported to maintenance at time of finding. 4. Director of Maintenance / designee will conduct audits to ensure single and double swinging doors closed and latched into frames and to ensure doors in common areas are not propped open with wedges. Director of Maintenance / designee will report findings to the QA committee monthly x3 months to ensure compliance.	2/20/17
K 700 SS=E	NFPA 101 Operating Features - Other Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags,	K 700	1 Signage for the South Office, Social Room, Quality Assurance and Training Room, Food and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 700	Continued From page 5 but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that doors and/or walls in resident care areas lacked signage to identify their function or purpose in eight (8) of 10 observations. These findings were observed in the presence of the Maintenance Director. The findings include: During a tour of the facility it was determined that signage was not present on patient entrance doors, hallway walls or outside common areas to identify the location of patient rooms and patient care areas in the following instances: Fifth Floor The South Office, and Social Room in two (2) of four (4) observations between 2:45 and 3:00 PM on January 18, 2017. Fourth Floor The Quality Assurance and Training Room in one (1) of one (1) observation at 3:15 PM on January 18, 2017. Third Floor The Food and Nutrition Office and the South Storage Room in two (2) of two (2) observations between 3:20 PM and 3:30 PM on January 18, 2017.	K 700	Nutrition Office, South Storage Room, Clean Linen Room, Patient Room 214, and Training Office has been ordered and will be installed when received. 2. Director of Maintenance / designee conducted an audit to ensure signage is present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. 3. Director of Maintenance / designee will in-service facility staff to ensure that signage is present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. Issues should be reported to maintenance at time of finding. 4. Director of Maintenance / designee will conduct audits to ensure signage is	2/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 700	Continued From page 6 Second Floor The Clean Linen Room, Patients Room 214 and Training Office in three (3) of three (3) observations at 3:40 PM on January 18, 2017.	K 700	present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. Director of Maintenance/ designee will report findings to the QA committee monthly x3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW WASHINGTON, DC 20037**

(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
K 000	INITIAL COMMENTS The following findings were identified during the Life Safety Code survey conducted January 18, 2017.	K 000		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: A. Based on observations during the Life Safety Code Inspection; it was determined that sprinklers, shaft surfaces and/or escutcheon rings were soiled with dust, paint or other debris which could potentially hamper the operation of sprinklers in the event of an emergency in 11 of 15 observations. These findings were observed in the presence of the Director of Maintenance. The findings include:	K 353	1 Dust was removed from sprinklers and escutcheon rings in 3 East Clean Linen Room, Rehab Department, 5 South Pantry Room, room 312 and room 413. Rusty sprinkler head and escutcheon ring in janitor closet closet located in the lobby was replaced with new sprinkler head and escutcheon ring. Paint on sprinkler heads and escutcheon rings in rooms 312, 118 and first floor supply closet were removed. Facility stand pipe caps will be Inspected by an outside vendor. 2 Director of Maintenance/designee	2/20/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW WASHINGTON, DC 20037**

(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
K 353	Continued From page 1 1. Dust and rust accumulation was observed on sprinkler head, shaft surfaces and escutcheon rings in eight (8) of 15 observations as follows: 3 East Clean Linen Room in one (1) of one (1) observation Rehabilitation Department in three (3) of four (4) observations 5 South Pantry Room in one (1) of two (2) observations Room 312 in one (1) of two (2) observations Room 413 in one (1) of one (1) observation Janitorial Closet located in the Lobby in one (1) of one (1) observation The findings were observed in the presence of the Director of Engineering between 2:00 PM and 4:05 PM on January 18, 2017. 2. Paint was observed on sprinkler heads and escutcheon rings in three (3) of 15 observations as follows: Toilet Room 312 in one (1) of one (1) observation Room 118 in one (1) of two (2) observations First Floor Supply Closet in in one (1) of one (1) observation The findings were observed in the presence of the Director of Engineering between 4:05 PM and 5:05 PM on January 18, 2017.	K 353	conducted an audit of sprinkler heads and escutcheon rings to ensure no dust, paint, or other debris that could potentially hamper the operation of sprinklers was present. Director of Maintenance / designee conducted an audit of stand pipe caps to ensure they are loosely maintained to ensure easy access by Fire Department in the event of an emergency. 3.Director of Maintenance/designee will in-service maintenance staff on ensuring there is no presence of dust, paint, or other debris on sprinkler heads and escutcheon rings that could potentially hamper the operation of sprinklers. Director of maintenance / designee will in-service maintenance staff to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW WASHINGTON, DC 20037**

(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
K 353	Continued From page 2 B. Based on observations during the Life Safety Code Inspection, it was determined that standpipe caps which are a part of the Automatic Sprinkler System were not maintained to allow easy access by the Fire Department in the event of an emergency in seven (7) of 10 observations. These findings were observed in the presence of the Maintenance Director. The findings include: Standpipe caps were not loosely maintained in 7 of 10 observations to ensure easy access by the Fire Department in the event of an emergency in the following areas. <u>Third Floor</u> 3 North Stairwell 3 West Stairwell 3 East Stairwell. <u>Second Floor</u> 2 East Stairwell 2 North Stairwell <u>First floor</u> 1 East Stairwell, 1 West Stairwell	K 353	ensure stand pipe caps are loosely maintained to ensure easy access by Fire Department in the event of an emergency. 4. Director of maintenance/designee will conduct audits of sprinkler heads and escutcheon rings to ensure no dust, paint, or other debris that could potentially hamper the operation of sprinklers is present. Director of maintenance / designee will conducted audits of stand pipe caps to ensure they are loosely maintained to ensure easy access by Fire Department in the event of an emergency. Director of Maintenance / designee will report audit findings to the QA committee monthly X 3 months to ensure compliance.	2/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 353	Continued From page 3 The observations were conducted in the presence of the Maintenance Director who acknowledged the findings between 3:15 PM and 4:35 PM on January 18, 2017.	K 353		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363	1.Entrance doors located near the end of unit 2 south, room 502, and room 516 have been ordered and are to be replaced by an outside vendor. Wedges and/or door stops improperly holding doors open were removed at the time of survey. 2. Director of Maintenance / designee conducted an audit of single and double swinging doors to ensure they closed and latched into frames and of doors in common areas to ensure they were not propped open with wedges. 3. Director of Maintenance / designee will educate facility staff on ensuring single and double swinging doors close and latch into frames and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW WASHINGTON, DC 20037**

(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
K 363	Continued From page 4 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that single and double swinging doors failed to close and latch into frames when tested and doors in common areas were propped open with wedges in five of six (6) of 15 observations. These findings were observed in the presence of the Maintenance Director The findings include: 1. The entrance door located near the end of Unit 2 South was damaged and failed to close when tested in one (1) of six (6) observations at 4:10 PM on January 18, 2017. 2. Doors located between the Dining Room and the Main Kitchen and in the Dietary Storage Room were improperly held open with wedges and/or door stops which would impede the doors from closing in the event of an emergency, in three (3) of three (3) observations at 2:15 PM on January 18, 2017. 3. Entrance doors to Rooms 502 North and 516 North failed to close and latch into frames when tested in two (2) of six (6) observations between 2:45 PM and 3:10 PM on January 18, 2016.	K 363	ensure doors in common areas are not propped open with wedges. Issues should be reported to maintenance at time of finding. 4. Director of Maintenance / designee will conduct audits to ensure single and double swinging doors closed and latched into frames and to ensure doors in common areas are not propped open with wedges. Director of Maintenance / designee will report findings to the QA committee monthly x3 months to ensure compliance.	2/20/17
K 700 SS=E	NFPA 101 Operating Features - Other Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags,	K 700	1 Signage for the South Office, Social Room, Quality Assurance and Training Room, Food and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 700	Continued From page 5 but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that doors and/or walls in resident care areas lacked signage to identify their function or purpose in eight (8) of 10 observations. These findings were observed in the presence of the Maintenance Director. The findings include: During a tour of the facility it was determined that signage was not present on patient entrance doors, hallway walls or outside common areas to identify the location of patient rooms and patient care areas in the following instances: Fifth Floor The South Office, and Social Room in two (2) of four (4) observations between 2:45 and 3:00 PM on January 18, 2017. Fourth Floor The Quality Assurance and Training Room in one (1) of one (1) observation at 3:15 PM on January 18, 2017. Third Floor The Food and Nutrition Office and the South Storage Room in two (2) of two (2) observations between 3:20 PM and 3:30 PM on January 18, 2017.	K 700	Nutrition Office, South Storage Room, Clean Linen Room, Patient Room 214, and Training Office has been ordered and will be installed when received. 2. Director of Maintenance / designee conducted an audit to ensure signage is present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. 3. Director of Maintenance / designee will in-service facility staff to ensure that signage is present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. Issues should be reported to maintenance at time of finding. 4. Director of Maintenance / designee will conduct audits to ensure signage is	2/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
K 700	Continued From page 6 Second Floor The Clean Linen Room, Patients Room 214 and Training Office in three (3) of three (3) observations at 3:40 PM on January 18, 2017.	K 700	present on patient entrance doors, hallway walls, and outside common areas to identify the location of patient rooms and patient care areas. Director of Maintenance/ designee will report findings to the QA committee monthly x3 months to ensure compliance.	