STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHABILITATION HADLEY	**4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032**

(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 are based on observation and staff interview during the Life Safety Code survey on October 23, 2015.	K 000		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that two (2) of 15 doors observed failed to close and latch into frames to prevent the passage of smoke in the event of fire . These findings were observed in the presence of the Maintenance Director. The findings include:	K 018	1. The pantry entrance door that failed to close and latch into the door frame was repaired. The day room door on 3 East that failed to close and latch into the door frame was repaired. 2. All other doors were checked on 3 East and 3 West for proper closing and latching. No other door issues were found. 3. The Director of Maintenance or designee will check the doors and latches for proper operations during their monthly environmental rounds. 4. The Director of Maintenance or designee will report the finding of these rounds at the Quality Assurance Committee Meeting quarterly.	12/10/15

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

Administrator 11-28-15

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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K 018	Continued From page 1 1. During a tour of the facility it was determined that the Pantry entrance door failed to close and latch into the door frame without assistance when tested in one (1) of seven (7) observations on unit 3 West at 12:45 PM on October 23, 2015. 2. During a tour of unit 3 East, it was determined that the Day Room door failed to close and latch into the door fame in one (1) of eight (8) observations at 1:15 PM on October 23, 2015. NFPA 19.3.6.3.6.	K 018		
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that Fire Drills were not consistently conducted under varying conditions and times during each quarter, on each shift to familiarize staff and residents with procedures in the event of a fire. These findings were observed in the presence of the Maintenance and Safety Directors. The findings include: During a review of Fire Drill Logs, it was determined that unexpected Fire Drills were not conducted at varying times and conditions on each shift to ensure that staff are familiar with policies and procedure to establish a routine of familiarity during each Fire Drill.	K 048	1. The Director of Security acknowledged that unexpected Fire Drills were not conducted at varying time and conditions according to policies and procedures. 2. No resident was affected by this deficient practice. 3. The Director of Security or designee will reeducate the staff on conducting fire drills at varying times and conditions on each shift to ensure that the staff is familiar with policies and procedures to establish a routine of familiarity during each Fire drill. The Director of Security or designee will monitor these fire drills quarterly for compliance. 4. The Director of Security or designee will report their findings at the Quality Assurance Committee meeting Quarterly.	12/10/15

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K 048	Continued From page 2 Documentation was not available to substantiate that a drill was conducted on the Second Shift (7AM and 3PM) during the First Quarter of 2015 (January, February and March) in one (1) of 12 Fire Drill logs reviewed at 2:31 PM on October 23, 2015. NFPA 18.7.1.1 and 19.7.1.1	K 048		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety code Inspection, it was determined that sprinklers heads, shafts and escutcheon rings were not maintained and free of dust and paint to ensure proper operation in the event of an emergency in four of 11 observations. The findings include: Through observation and interview, it was determined that sprinkler heads, shafts and escutcheon surfaces were not maintained properly to ensure proper operation of sprinklers in the event of an emergency. Dust and paint was observed on the shaft, head and escutcheon ring surfaces of sprinklers in Room 339, 303 304 and the Clean Linen Room in four (4) of 11 observations between 11:30 AM and 2:30 PM on October 23, 2015. NFPA 18.7.6	K 062	1. The Director of Maintenance acknowledged the observation of dust and paint on the shaft , head and escutcheon ring surfaces of the sprinklers in rooms 339, 303 304 and the clean linen room. 2. All other sprinklers were checked dust and paint. No other soiled sprinklers were found. 3. The Director of Maintenance or designee will clean the sprinklers in rooms 339, 303 304 and the clean linen room. The Director of Maintenance or designee will audit the condition sprinkler heads during their monthly environmental rounds. 4. The Director of Maintenance or designee will report the finding of these rounds at the Quality Assurance Committee Meeting quarterly.	12/10/15

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K 062	Continued From page 3 and NFPA 13.	K 062		12/10/15