STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB OF WASHINGTON DC	**1380 SOUTHERN AVE SE 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 were identified during the Life Safety Code Inspection conducted August 25, 2016.	K 000	Brinton Woods of Washington D.C. LLC, "BWDC" is filing this Plan of Correction in accordance with the Compliance requirements for	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that double hallway and entrance doors to resident rooms failed to close and latch into frames when tested in six (6) of 20 observations. These findings were observed in the presence of the Maintenance Director. The findings include: 1. Double fire doors in hallways failed to close and latch into frames in two (2) of nine (9)	K 018	Federal and State regulations. This Plan of Correction constitutes the Facility's written allegation of Compliance for deficiencies cited. However submission of this Plan of Correction does not constitute Admission of facts or conclusions Cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 15 Sept 16

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 observations in the following locations: Second floor North Side near Room 218 Third Floor West Side near Room 318. 2. Doors located at the entrances to resident rooms and common areas failed to close and latch into frames when tested in four (4) of 11 observations in the following locations: First Floor Day Room Rehabilitation Therapy Laundry Room door that separates the Clean Side from the Soiled Side Room 145 The observations were made in the presence of the Maintenance Director on August 25, 2016 between 11:00 AM and 1:10 PM.	K 018	1. Double doors were adjusted and close properly First floor day room door adjusted and working properly Rehabilitation door latch ordered and will install upon arrival Laundry room doors adjusted and closing proper Room 145 door adjusted and closing properly now 2. Whole house audit conducted to ensure doors working properly. 3. Weekly rounds by both maintenance and environmental services supervisor will be conducted to ensure doors continue to work properly. 4. Maintenance Director and/or designee will be conducting weekly rounds monthly x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/05/16
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that penetrations were observed in wall surfaces above ceiling tiles; which would not prohibit the	K 025		

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K 025	Continued From page 2 passage of smoke in five (5) of nine (9) observations. These findings were observed in the presence of the Maintenance Director. The findings include: 1. A penetration approximately 1 ½ inches in diameter was observed in wall surfaces above ceiling tiles near the Rehabilitation entrance door in one (1) of one (1) observation at 11:10 AM on August 25, 2016. 2. Penetrations approximately 1 inch in diameter were observed in wall surfaces around a Conduit Pipe and BX Cable above the entrance door to the to the First Floor Day Room in two (2) of two (2) observations at 11:35 AM on August 25, 2016. 3. Two (2) penetrations approximately 4-6 inches in length were observed between the ceiling tile grid and wall surfaces above the Ansul Fire Suppressor Tank in the Main Kitchen in two (2) of two (2) observations at 11:15 AM on August 25, 2016. The observations were made in the presence of the Maintenance Director on August 25, 2016.	K 025	1. Penetration above ceiling tile near Rehabilitation entrance door sealed with fire barrier sealant. Penetration above entrance door to first floor day room sealed with fire barrier sealant. Two penetrations around ceiling grid and wall above Ansul system in main kitchen area sealed with fire barrier sealant. 2. House wide audit conducted above all ceiling tile for penetrations. 3. Weekly audits will be conducted by Maintenance to ensure integrity of smoke barrier walls and follow up on all contractors in building when running cables or piping or wires. 4. Maintenance Director and/or designee will be conducting weekly rounds monthly x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/05/16
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler	K 056		

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K 056	Continued From page 3 protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on a review of the facility ' s Sprinkler System documents, it was determined that documentation was not available to support testing of the Automatic Sprinklers System: Tamper, Flow Switches and Supervisory Valves to determine if devices failed or passed during 3 of 4 quarters reviewed. The findings include: During a review of the Automatic Sprinkler System Log; it was determined that test results (Pass of Fail) for the Automatic Sprinkler System were not recorded on Log sheets for Tamper; Flow Switches, Supervisor Valves and Alarm Devices. Quarterly test results for September 15, 2015; December 22, 2015 and March 4, 2016 lacked pass or failed test results in one (1) of one (1) observation of 3 of 4 quarters reviewed at 2:30 PM on August 25, 2016.	K 056	1. Testing for tamper and flow switches along with supervisor valves and alarm devices were tested and passed on all three of dates mentioned, however it was mentioned on a cover page of the report and not on the individual device listed. 2. Contacted BFPE and informed them on how we needed the report written to reflect that proper testing and pass or fail of each device. 3. Quarterly testing is on tickler file for maintenance to contact BFPE when due. 4. Maintenance Director and/or designee will be reporting tickler file testing changes monthly x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/05/16
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on a review of documents during the Life Safety Code Inspection, it was determined that the Fire Pump was not exercised each week as required to determine the efficiency of the Pump in one (1) of one (1) observation. These findings were observed in the presence of the Maintenance Director.	K 130		

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K 130	Continued From page 4 The findings include: During the Life Safety Code Inspection, it was determined that documentation was not available to determine if the Electric Fire Pump was operating properly to maintain proper water pressure during an emergency as required. There was a lack of documentation to reflect that weekly tests were conducted which consisted of checking the discharge and suction pressures; packing glands to determine if there are leaks; vibration checks, checks on packing boxes, bearings for overheating and determining the time it took to the motor to reach full speed in one (1) of one (1) observation at 3:50 PM on August 25, 2016. The findings were confirmed in the presence of the Maintenance Director who was present at the time of review. NFPA 25-8.3.1	K 130	1. Electric fire pump is on automatic weekly run cycle and is annually tested by BFPE 2. Contacted BFPE to in service us on proper logging of fire pump exercise. Will begin log on weekly test conducted on electric fire pump Log to begin after in-service by BFPE in September 2016 3. Maintenance Director to monitor weekly to ensure log is kept up to date. 4. Maintenance Director and/or designee will be conducting weekly rounds monthly x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions	10/05/16