STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 A Life Safety Code survey was conducted on September 9, 2015 to determine compliance with applicable provisions of the 2000 edition of the Life Safety Code. The survey was conducted through observations of the interior and exterior of the building and included the installed sprinkler system, smoke detectors, fire panel, etc., and through interviews with the facility's staff.	K 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submissions of this plan of correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents, as the truth of the facts alleged or validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and or executed because it is required by the State and Federal laws.	
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2	K 015	K015 A	
	This STANDARD is not met as evidenced by: A. Based on observation, three (3) of 200 ceiling tiles were missing throughout the facility. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, that ceiling tiles were missing in the following areas: 4th floor medication room is missing a ceiling Basement storage room laundry room 2 area		1. Missing ceiling tiles were replaced immediately. 2. Visual observations were conducted of the remaining ceiling tiles and were found to be in place. 3. Staff will be inserviced on the reporting protocol for missing/damaged ceiling tiles. 4. Weekly building observations to be conducted by the Director of Maintenance or designee. Findings will be presented at the quarterly QI/QA meeting.	9/9/2015 10/21/15 11/9/15 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bonnie Williams for Nina Sandri	Administrator	10/30/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 015	Continued From page 1 Basement laundry room chute area Creating a potential hazard for staff and residents in an event of an emergency. B. Based on observations, six (6) of 200 ceiling tiles were damaged. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility ceiling tile is damaged in the following areas: Penthouse next to the exit sign for stair 2 access. 5th floor pantry 5th East- nurse lounge 5th floor behind the nurse station 4th floor pantry above food warmer 4 East nurse lounge located above escutcheon plate Creating a potential hazard for staff and residents in an event of an emergency. C. Based on observations, penetrations were observed in three (3) of three ceiling/walls observed. The findings include: It was observed at approximately 10:00am	K 015	K 015B 1. Damaged ceiling tiles were replaced immediately. 2. Visual observations were conducted of the remaining ceiling tiles and none were found to be damaged. 3. Staff will be inserviced on the reporting protocol for missing /damaged ceiling tiles. 4. Weekly building observations to be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting. K 015C 1. Ceiling tiles and walls were repaired. 2. Visual observations were conducted of ceiling tiles and walls. No other penetrations were identified. 3. Maintenance staff will be in-serviced on identifying wall penetrations and proper sealing. 4. Weekly building observations to be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting.	9/9/15 9/9/15 11/9/15 Ongoing 10/26/15 10/26/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 015	Continued From page 2 through 2:00pm on September 9, 2015, the facility has ceiling/wall penetrations in the following areas: Basement laundry storage area 1st floor pool area ceiling 2 East bathing area	K 015		
K 018 SS=E	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: A. Based on observation, one (1) of two (2) doors in the kitchen pantry were not operable	K 018	K 018A 1. The identified door was repaired. 2. All other doors were inspected and found to be in good operating condition. 3. Staff will be in-serviced on the reporting protocol for door repairs. 4. Quarterly observations to be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting.	10/26/15 10/26/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 018	Continued From page 3 The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the kitchen pantry door hardware was not operable. Creating a potential hazard in an event of an emergency. B. Based on observation, seven (7) of 200 doors did not close and latch in the frame. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility doors in the following areas did not close and latch in the frame: Penthouse- stair 2 roof access door 5th floor- stair 2 door 4 South- activity room entry door 4 West- soiled utility door 3 South- activity room entry door 3 North- soiled utility door 3 East- Housekeeping door Creating a potential hazard in an event of an emergency. C. Based on observation, the magnetic hold-open device for one (1) of 10 doors was not working. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the laundry room door magnetic hold device on the 5th floor north wing was not working, posing a potential hazard.	K 018	K018B 1. Identified doors were repaired. 2. All other doors were inspected and observed to close properly. 3. Staff will be in-serviced on the reporting protocol for door repairs. 4. Quarterly observations will be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting. K018C 1. Magnetic hold device was repaired. 2. All other magnetic door devices were inspected and observed to operable. 3. Staff will be in-serviced on the reporting protocol for magnetic device repairs. 4. Weekly observations will be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QI/QA meeting.	10/26/15 10/26/15 11/9/15 Ongoing 10/26/15 10/26/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, three (3) of 50 exit signs were obstructed. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility exit signs were obstructed in the following areas: 5th floor north wing exit access 4 North wing exit access 3 North wing exit access Creating a potential hazard for staff and residents exiting the facility in an event of an emergency.	K 047	K047 1. Identified item was moved to avoid obstruction of exit signs immediately. 2. Visual observations were conducted and all exit signs were found to be free from obstruction. 3. Staff will be in-serviced on keeping exit and evacuation signs free of obstructions. 4. Weekly observations to be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting.	9/9/15 9/9/15 11/9/15 Ongoing
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible	K 050	K050 1. Facility conducted fire drills according to regulations. 2. Desired modifications to the fire drill documentation form will be updated as needed. 3. Staff will be in-serviced on completion of the updated fire drill documentation form. 4. Audits for proper documentation will be conducted after each fire drill by Security staff or designee. Results will be presented at the quarterly QA/QI meeting.	10/29/15 11/9/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 050	Continued From page 5 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide proper documentation that shows the fire drills have been performed quarterly or monthly. The findings include: Record and review at approximately 10:00am through 2:00pm on September 9, 2015, the facility failed to show proper documentation that shows the fire drills have been performed quarterly or monthly.	K 050	K051 1. The facility obtained a copy of the 2014 and 2015 annual Fire Alarm and Detection System Inspection Report from the third-party inspector. Reports will be forwarded to the regulatory agency. 2. Third-party inspector has been directed to send all inspection reports to Carroll Manor. 3. Inspection report(s) will be maintained in the Maintenance Department. 4. Quarterly observations by the Director of Maintenance or designee will be presented at the quarterly QA/QI meeting.	10/30/15 10/26/15 10/26/15 Ongoing
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 051	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide documentation that shows the fire alarm system has been maintain in accordance with NFPA or the authority having jurisdiction. The findings include: Record and review at approximately 10:00am through 2:00pm on September 9, 2015, the facility failed to provide documentation that shows the fire alarm system has been maintained in accordance with NFPA or the authority having jurisdiction.	K 051	K062A 1. The facility obtained a copy of the 2014 and 2015 quarterly automatic fire sprinkler system inspection report from the third-party inspector. Reports will be forwarded to the regulatory agency. 2. Third-party inspector has been directed to send the inspection report(s) to Carroll Manor 3. Inspection report(s) will be maintained in the maintenance department. 4. Quarterly observations by the Director of Maintenance or designee will be presented at the quarterly QA/QI meeting.	10/30/15 10/26/15 10/26/15 Ongoing
K 062 SS=F	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: A. Based on observation, the facility failed to provide documentation that shows the sprinkler system has been maintained in accordance with NFPA or the authority having jurisdiction. The findings include:	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING 01 - **MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 062	Continued From page 7 Record and review at approximately 10:00am through 2:00pm on September 9, 2015, the facility failed to provide documentation that shows the sprinkler system has been maintained in accordance with NFPA or the authority having jurisdiction. B. Based on observation, one (1) of 250 sprinkler heads one (1) of 250 needed repositioning. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility sprinkler head in the pantry on the 5th floor needed repositioning. Creating a potential hazard in an event of an emergency. C. Based on observation, twenty-one (21) of 250 sprinkler heads were dust laden. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility sprinkler heads in the following areas were dust laden: 5th floor pantry 5th floor cafeteria 5 West electrical closet 5 North soiled linen chute 4th floor kitchen	K 062	K062B Identified sprinkler head was inspected and repositioned. 1. Visual observations were conducted of the remaining sprinkler heads. And all were found to be properly positioned. 2. Maintenance staff will be in-serviced on visual observation of sprinkler heads to ensure proper positioning. 3. Monthly inspections to be conducted by the Director of Maintenance or designee. All findings will be presented at the quarterly QA/ QI meeting. K062C 1. Identified sprinkler heads will be replaced by a third party vendor. 2. All remaining sprinkler heads were visually observed and found to be free of dust. 3. Maintenance staff will be in-serviced on observing the sprinkler heads to ensure they are dust free. 4. Monthly observations to be conducted by the Director of Maintenance. All findings will be presented at the quarterly QA/QI meeting.	10/28/15 10/28/15 11/9/15 Ongoing 11/5/15 11/9/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 062	Continued From page 8 Room 449 4 West day room 3rd floor kitchen 3rd floor soiled linen chute 3 North soiled linen room 1st floor dinning area Gift shop 1st floor lobby waiting area Basement kitchen and dining area Basement housekeeping Maintenance shop Cart wash area Resident storage room 2nd floor living room 2nd floor dining room Room 102 Creating a potential hazard in an event of an emergency. D. Based on observation, three (3) of 250 escutcheon plates were missing.	K 062	K062D 1. The identified missing escutcheon plates were replaced. 2. Remaining escutcheon plates were observed by the maintenance staff and found to be in place. 3. Maintenance staff will be in-serviced on the reporting protocol for missing escutcheon plates. 4. Weekly observations to be conducted by the Director of Maintenance. All findings will be presented at the quarterly QA/QI meeting.	10/29/15 10/29/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 062	Continued From page 9 The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility escutcheon plates were missing in the following areas: 5th floor pantry 5th floor center core day room Room 114 Posing a potential hazard in an event of an emergency. E. Based on observation, two (2) of 250 escutcheon plates were corroded in the following areas: Pool area 1st floor activity room F. Based on observation, three (3) of 14 standpipe caps were tight. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility standpipe caps were too tight in the following areas: Penthouse stair 2 roof access 4th floor stair 2 level 4 3rd floor stair 2 level 3	K 062	K062E 1. Identified corroded escutcheon plate was replaced. 2. Remaining escutcheon plates were observed and were found to be free of corrosion. 3. Maintenance staff will be in-serviced on the reporting protocol for corroded escutcheon plates. 4. Weekly observations to be conducted by the Director of Maintenance or designee. All findings will be presented at the quarterly QA/QI meeting. K062F 1. Identified standpipe caps were loosened immediately. 2. Maintenance staff inspected and adjusted each stairwell standpipe cap as necessary. 3. Maintenance staff will be in-serviced on standpipe protocols. 4. Quarterly observations by the Director of Maintenance or designee will be presented at the quarterly QA/QI meeting.	10/26/15 10/30/15 11/9/15 Ongoing 9/9/15 10/29/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 062	Continued From page 10 Creating a potential hazard in an event of an emergency.	K 062		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation, decorations were observed hanging from the ceiling in three (3) of 3 observations on the 5th floor. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility has decorations hanging from the ceiling in the following areas: 5th west exit corridor 5th floor stair 3 exit door 5th floor 507 and 508 Creating a potential hazard in an event of an emergency.	K 073	K073 1. All highly flammable decorations observed hanging from the ceiling on the 5th floor were immediately removed. 2. All units were inspected to ensure compliance and no highly flammable decorations were observed. 3. Staff will be in serviced on use of proper decorations within the facility. 4. Monthly rounds and audits will be conducted by the Activity Manager or designee to ensure compliance with regulations. All findings will be reported to the quarterly QI/QA meeting.	9/9/15 9/9/15 11/9/15 Ongoing
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 130	Continued From page 11 A. Based on observation, six (6) of six surge protectors observed were not mounted. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, surge protectors were not mounted in the following areas: 5th floor nurses main office 4th South activity room 4th floor charting room 3 South social worker office 3rd floor manager office 3rd floor charted area Posing as a potential hazard in an event of an emergency. B. Based on observation, one (1) of 1 laundry room dryer had dust build up. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility dryer has dust build up behind it. Creating a potential hazard in an event of an emergency. C. Based on observation, the facility has storage greater than 18 inches from the sprinkler head in two (2) of 2 locations observed.	K 130	K130A 1. Identified surge protectors were mounted. 2. Maintenance staff will conduct observations to ensure that all surge protectors are properly mounted. 3. Staff will be in-serviced on proper surge protector mounting protocol. 4. Weekly observations will be conducted by department heads or designees. Results will be presented at the quarterly QA/QI meeting. K130B 1. The identified dryer was cleaned immediately. 2. All facility dryers were observed and found to be dust free. 3. Staff will be in-serviced on identifying dust build up and cleaning procedures. 4. Monthly observations will be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting.	9/9/15 11/9/15 11/9/15 Ongoing 9/9/15 9/9/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 130	Continued From page 12 The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility has storage greater than 18 inches from the sprinkler head in the following areas: 5 west corridor 3 west storage room Creating a potential hazard in an event of an emergency. D. Based on observation, the facility has storage less than 6 inches off the floor in eight (8) of 8 locations observed. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, the facility has storage less than 6 inches off the floor in the following areas: 3rd floor social worker office 5 West corridor 5 North corridor Laundry room storage room 2 Laundry room storage room 1 Kitchen office area Business office	K 130	K130C 1. Identified storage was placed 18" below the sprinkler head. 2. Observations will be conducted of storage areas and contents were found to be 18" below the sprinkler heads. 3. Staff will be in-serviced on regulatory guidelines for storage. 4. Random observations to be conducted by the Director of Maintenance or designee. All findings will be presented at the quarterly QA/QI meeting. K130D 1. Identified boxes were removed immediately and stored appropriately. 2. Observations will be conducted to ensure all boxes are properly stored off of the floor. 3. Staff will be in-serviced on regulatory guidelines for storage. 4. Random observations to be conducted by the Director of Maintenance or designee. All findings will be presented at the quarterly QA/QI meeting.	9/9/15 11/5/15 11/9/15 Ongoing 9/9/15 11/5/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE WASHINGTON, DC 20017**

(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 130	Continued From page 13 Staff education room Creating a potential hazard in an event of an emergency. E. Based on observation, one (1) of 1 oxygen tank was stored unsecured. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, one (1) of 1 oxygen tank in the storage room was unsecured. Creating a potential hazard in an event of an emergency. 2000 Life Safety Code-LSC 8.3.6.2 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. F. Based on observation, one (1) of 1 penetration was observed in the floor surface. The findings include: It was observed at approximately 10:00am through 2:00pm on September 9, 2015, that the	K 130	K130E 1. Identified tank was removed. 2. No other tanks were found to be improperly stored. 3. Staff will be in-serviced on the proper storage of tanks. 4. Monthly random observations to be conducted by the shift managers or designees. All findings will be presented at the quarterly QA/QI meeting. K130F 1. Identified floor penetration was sealed immediately. 2. No other floor penetrations were identified. 3. Maintenance staff will be in-serviced on identifying floor penetrations and proper sealing. 4. Random monthly observations will be conducted by the Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting.	9/9/15 9/9/15 11/9/15 Ongoing 9/9/15 9/9/15 11/9/15 Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	**725 BUCHANAN ST., NE** **WASHINGTON, DC 20017**

(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 130	Continued From page 14 penthouse had a penetration in the floor on the left hand corner opposite the roof access door storage mechanical room.	K 130		