STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING **02 - LOCATED AT PROVIDENCE HOSP 5 EAST** B. WING _____	**09/22/2016**

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 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Inspection; it was determined that weekly Fire Pump exercises were not recorded on log sheets in 10 of 10 observations and air supply vents were soiled with dust in three (3) of seven (7) observations. These findings were observed in the presence of the Maintenance Director. The findings include: 1. Weekly Fire Pump exercise times were not recorded on log sheets to indicate the start and the finish times of each exercise; to validate the testing of the Fire Pump each week in 10 of 10 observations on September 22, 2016. 2. Air supply and exhaust vents were soiled with excessive dust and other debris in the following locations: a. First floor Pantry in one (1) of five (5) observations b. The dishwasher area of the of the Main Kitchen in two (2) of two (2) observations These findings were observed between 2:00 PM and 3:15 PM on September 22, 2016 in the presence of maintenance staff.	K 130	**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 fact alleged or the 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.** **K130 (1)** **1(A).**Fire pump log was updated to include Start and finish times for exercises. 10/1/16 **2(A).**Logs will properly identify run times. 10/1/16 **3(A).**Logs will be maintained in the Maintenance department 10/1/16 **4(A)**Quarterly observations to be conducted by The Director of Maintenance or designee. Results Will be presented during the quarterly QA/QI meeting ongoing **K130 (2)** **1(B)**The identified vents were cleaned by Maintenance personnel. 11/1/16 **2(B).**All remaining vents were visually Observed and found to be free of debris/dust. 11/1/16 **3(B)**Maintenance staff was inserviced on observing The vents to ensure that they are free of dust. 11/1/16 **4(B)** Monthly observations will be conducted by The Director of Maintenance or designee. Results will be presented at the quarterly QA/QI meeting. Ongoing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolina C. McCleese TITLE: VP-Admin (X6) DATE: 11/7/16

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.

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 _____	**09/22/2016**

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

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K 000	INITIAL COMMENTS The following findings were identified during the Life Safety Code Inspection conducted September 22, 2016.	K 000		
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 Survey Inspection; it was determined that double and single swinging doors failed to close and latch into frames when tested in four (4) of four (4) observations. These findings were observed in the presence of the Maintenance Director. The findings include: 1.Double doors located at the entrance to Units 1 North and 1 West failed to close and latch when	K 018	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 fact alleged or the 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. K018 1.The identified doors were repaired. 2. All doors were inspected and found to be in good operating condition 3.Maintenance staff was –in-serviced on Responding to door repair requests. 4. Quarterly observations will be conducted by the Director of maintenance or designee. Results will be presented during the quarterly QA/QI meeting.	9/23/16 9/22/16 11/1/16 Ongoing

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

Marlena C McAllister, VP-Admin 11/7/16

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.

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 _____	**09/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018	Continued From page 1 tested at 11:15 AM in two (2) of two (2) observations on September 22, 2016. 2. The single swinging door located at the entrance to Rehabilitation Services failed to close and latch into frame when tested in one (1) of one (1) observation at 3:20 PM on September 22, 2016. 3. The men's bathroom door in the basement failed to close and latch without assistance in one (1) of one (1) observation at 3:25 PM on September 22, 2016.	K 018		
K 062 SS=E	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 observations during the Life Safety Code Inspection; it was determined that sprinklers were not maintained to ensure proper operation in the event of an emergency as evidenced by a buildup of dust and other soiled products on sprinkler head and shaft surfaces in 39 of 53 observations. These findings were observed in the presence of Maintenance Staff. The findings include: Basement Level observations: 1. Sprinkler head and shaft surfaces were soiled with dust accumulation in Stairwell #2 in two (2) of two (2) observations at 1:45 PM on September 22, 2016.	K 062	K062 1. All identified sprinkler heads were cleaned by maintenance personnel. 2. All remaining sprinkler heads were visually Observed and found to be free of debris and Dust. 3. Maintenance staff was in-serviced on Observing the sprinkler heads to ensure that They are free of dust. 4. Monthly observations will be conducted by The Director of Maintenance or designee. Results will be presented during the quarterly QA/QI meeting	11/1/2016 11/1/2016 11/1/2016 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 _____	**09/22/2016**

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K 062	Continued From page 2 2. Sprinkler cap covers and sprinkler supply lines under cooking hoods in the Main Kitchen were soiled with dust and grease accumulation in three (3) of three (3) observations at 1:50 PM on September 22, 2016. 3. The metal sprinkler guard in the walk in refrigerator was soiled with dust and other debris in one (1) of one (1) observation at 1:40 PM on September 22, 2016. 4. Sprinkler head and shaft surfaces were soiled with dust accumulation in the Main Kitchen Storage Room in one (1) of one (1) observation at 1:45 PM on September 22, 2016. 5. Sprinkler head and shaft surfaces were soiled with dust and debris on the shaft and head surfaces in the Housekeeping Room in three (3) of four (4) observations at 1:50 PM on September 22, 2016. Sprinkler head and shaft surfaces were soiled with dust and/or debris on the First Floor as follows: 1. First Floor Pantry Room in two (2) of two (2) observations 2. Room 144 in two (2) of two (2) observations 3. Day Room in four (4) of four (4) observations 4. Laundry Room in two (2) of two (2) observations 5. Break Room in one (1) of one (1) observation 6. Housekeeping Closet in one (1) of one (1) observation 7. Stairwell #5 in one (1) of one (1) observation 8. First Floor Treatment Room in 11 of 12 observation	K 062		

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K 062	Continued From page 3 9. Men's Locker Room one (1) two (2) observations 10. Women ' s Locker Room in one (1) of two (2) observations 12. Swimming Pool Area in four (4) of nine (9) observations Second Floor Findings Sprinkler head and shaft surfaces were soiled with dust accumulation in the Second Floor Dining Room in two (2) of two (2) observations and the Second Floor Pantry in one (1) of two (2) observations. These findings were observed between 3:15 PM and 4:15 PM on September 22, 2016 in the presence of maintenance staff.	K 062		