DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	08/18/2009

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 recertification survey was conducted at your facility on August 18, 2009. The following deficiencies are based on observations and staff interview.	K 000	**Start Typing Here:** **Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submission 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 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.**	
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. Based on observations during the Life Safety Code Inspection it was determined that double swinging fire doors and entrance doors failed to close and latch when tested at the entrances to the Bathing Room and Soiled Linen Room in two (2) of seven (7) observations on unit Five West, Five North Clean Linen, Soiled Linen Room and the entrance door to room 533 failed to latch into	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: E. Buchanan NHA — TITLE: Administrator — (X6) DATE: 9.18.09

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 frames in three (3) of four (4) observations, Five East entrance door to room 511 failed to close and latch into door frame when tested in one (1) of seven (7) observations, Four West Dining Room door located near the entrance failed to close or latch when tested in one (1) of one (1) observation, Four West Dining Room door located near the entrance to the unit failed to close or latch when tested in one (1) of one (1) observation, Three West, Three West Pantry and Dining Room doors located near the entrance to the third floor failed to close and latch into the door frames when tested in two (2) of two (2) observations, single doors failed to latch when tested at the entrances to the Cafeteria, Staff Rest Room and Clean Linen Room in three (3) of seven (7) observations, double swinging fire doors located at the entrance to the unit failed to latch into frames when tested in one (1) of one (1) observation, entrance doors to the Conference Center, Two West Cafeteria and Clean Room failed to close without assistance and latch into frames when tested in three (3) of eight (8) observations, double smoke barrier doors located the entrance to the Marta Rehab Center failed to close without assistance when tested in one (1) of six (6) observations and basement entrance doors to the Dishwasher and Resident Belongings Rooms failed to close and latch into frames when tested in two (2) of ten observations. The findings include: Double swinging fire and entrance doors to resident ' s rooms and common areas failed to close and latch into frames when tested in the following areas.	K 018		

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K 018	Continued From page 2 Five West Single doors failed to latch into frames at the entrances to the Bathing Room and Soiled Linen Room in two (2) of seven (7) observed doors at 9:05 AM on August 18, 2009. Five North The Clean Linen, Soiled Linen Room and the entrance door to room 533 failed to latch into frames in three (3) of four (4) observed doors at 9:25 AM on August 18, 2009. Five East The entrance door to room 511 failed to close and latch into door frame when tested in one (1) of seven (7) observed doors at 9:35 AM on August 18, 2009. Four West The Dining Room door located near the entrance to four west failed to close or latch when tested in one (1) of one (1) observed doors 9:50 AM on August 18, 2009. Three West 1. The Pantry and Dining Room doors located near the entrance to the third floor failed to close and latch into the door frames when tested in two (2) of (2) two observed doors 10:00 AM on August 18, 2009. 2. Double swinging fire doors located at the entrance to the unit failed to latch into frames when	K 018	**K018 – NFPA 101 Life Safety Code Standard** a) Corrective work orders were generated and issued for these door(s) (all locations) where the door(s) failed to properly latch. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d) Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance	9/25/09 9/30/09 9/25/09

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K 018	Continued From page 3 at 10:30 AM on August 18, 2009. 3. Single doors failed to latch when tested at the entrances to the Cafeteria, Staff Rest Room and Clean Linen Room in three (3) of seven (7) observed doors at 10:40 AM on August 18, 2009. Two West The entrance doors to the Conference Center, Cafeteria and Clean Room failed to close without assistance and latch into frames when tested in three (3) of eight (8) observed doors at 11:15 AM on August 18, 2009. First Floor West Double smoke barrier doors located the entrance to the Marta Rehab Center failed to close without assistance when tested in one (1) of six (6) observed doors at 12:45 PM on August 18, 2009. Basement The entrance doors to the Dishwasher and Resident Belongings Rooms failed to close and latch into frames when tested in two (2) of ten observed doors at 1:00 PM on August 18, 2009. Through interview with the Safety Officer and Maintenance Director, employees # 30 and #31, during the life safety code tour (on August 18, 2009) the aforementioned observations were confirmed.	K 018	**K130 (1) NFPA101 Miscellaneous** a) Corrective work orders were generated and issued for the ceiling tiles. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d) Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance **K130 (2) NFPA101 Miscellaneous** a) Corrective work orders were generated and issued for the elevator pit surfaces. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d) Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance	**9/25/09** **9/18/09**
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 4	K 130		
	This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that ceiling tiles were soiled and failed to fit into grids in five (5) of 18 observations, elevator pit # 1 was observed to have a collection of debris on pit surfaces in one (1) of three (3) observations, damaged floor tiles in the basement hallway in one (1) of one (1) observation, improper storage of boxes and supplies on floor surfaces in three (3) of three (3) observations and damaged wall tiles in one (1) of one (1) observation. The findings include: 1. Ceiling tiles were soiled and stained and failed to fit into grids in residents rooms and common areas, 5 North Soiled Utility Room, 1st Floor Soiled Utility Room, Basement hallway near the tank room, hallway areas near the Morgue and Materials Management Storage Room in five (5) of 18 observed locations between 9:05 AM and 1:50 PM on August 18, 2009. 2. The elevator pit surfaces were observed to have accumulated leaves and paper products on pit floor surfaces in one (1) of three (3) observed elevators at 1:40 PM on August 18, 2009. 3. Floor tiles in the basement hallway near the tank room were observed to be to be damaged, uneven and separated from floor surfaces in one (1) of one (1) observed area on August 18, 2009. 4. Four boxes of supplies were observed on floor surfaces in the Laundry Storage Room in three (3) of three (3) observed locations (in the Laundry		**K130 (3) NFPA101 Miscellaneous** a) Corrective work orders were generated and issued for the damaged floor tiles. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d) Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance **K130 (4) NFPA101 Miscellaneous** a) Corrective work orders were generated, issued and completed for the improperly stored boxes of supplies. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d) Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance	9/30/09 8/26/09

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K 130	Continued From page 5 storage area) at 1:35 PM on August 18, 2009. 5. Wall surfaces in the Cart Wash Room were observed to be damaged and tiles were missing on corner surfaces in one (1) of one (1) observed area at 1:45 PM on August 18, 2009. Through interview with the Safety Officer and Maintenance Director, employees # 30 and #31, during the life safety code tour (on August 18, 2009) the aforementioned observations were confirmed.	K 130	**K130 (5) NFPA101 Miscellaneous** a) Corrective work orders were generated and issued for the wall surfaces that were damaged. b) Other related areas were surveyed, as a result of the indicated deficiency, for other indicators or deficient practice to include in this improvement plan c) Deficient practices will be monitored via monthly environmental rounds and semi annual; EOC Rounds. d). Deficiencies revealed during these rounds will be logged, corrected and reported to the QI committee on a quarterly basis to assure a minimum of 95% compliance	10/2/09