STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	**5000 BURROUGHS AVE. NE WASHINGTON, DC 20019**

(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 observed during the Life Safety Code Survey at your facility on February 25, 2014.	K 000		
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: Based on observations during the Life Safety Code Inspection, it was determined that single and double swinging doors failed to close and latch into frames; doors at the entrances to common areas were propped open with a wedge; openings were observed a storage room door and fire and entrance doors to common areas were impeded from closing in 12 of 48 door	K 018	Please begin typing here: K018 1A. The double swinging fire doors located near the lower level classroom was repaired on 2/27/14. B.The soiled side main laundry room entrance door was repaired on 2/27/14. C.The hallway door outside of the main laundry room was repaired on 2/25/14. D.The laundry room storage room door was repaired on 2/27/14. E.The soiled linen room door on 2N was repaired on 2/27/14. F.The entrance door to the multi proposes room on 2S was repaired on 2/27/14. G.The double swinging fire doors on 3S were repaired on 2/28/14. H.The entrance door to room 424 was repaired on 2/28/14. I.The entrance door to room to 505 was repaired on 2/28/14. 2.All residents have the potential to be affected by this deficient practice. A weekly tour will be done by the Maintenance Director/Designee to ensure that all fire doors and corridor doors will be operating and maintained properly; any deficient areas will be repaired immediately by the Director of Maintenance/Designee .	

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

Administrator — 5/9/14

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. These findings were observed in the presence of the Maintenance Director and the Assistant Director of Maintenance. The findings include: Lower Level The following findings were observed during the walk through inspection, double doors and single swinging doors failed to close and latch into frames, doors at the entrances to common area were propped open with wedges, cylindrical openings were observed in fire doors and entrance doors in a common area were impeded from closing. A. Double swinging fire doors failed to close and latch into frames when tested near the Lower Level Classroom in two (2) of two (2) observations on February 25, 2013 at 11:45 AM. B. The Soiled Side Main Laundry Room entrance doors failed to close when tested in one (1) of four (4) observations at 12:15 PM on February 25, 2014. C. The hallway door outside of the Main Laundry Room and the inner door that separates the clean side from the dryer area were improperly held open with a wedge in two (2) of two (2) observations at 12:10 PM on February 25, 2014. D. The Housekeeping Storage Room door was observed to have two (2) cylindrical openings in two (2) of two (2) observations at 12:50 PM on February 25, 2014.	K 018	3. A monthly audit tool was initiated and implemented by the Maintenance Director to ensure all doors protecting corridor openings will be operating and maintained properly. The audit tool will be reviewed by the Maintenance Director/Designee. Any required maintenance on the fire doors will be repaired immediately upon the deficient findings. All Maintenance Department staff were provided in-service education on all deficient findings. 4. Quarterly meetings will be held with the QAPI team and monthly reporting will be reviewed by the Maintenance Director and the entire management team.	5/13/14

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K 018	Continued From page 2 Second Floor A. The Soiled Linen Room door on Unit 2N was observed to have a cylindrical opening, which would not prevent the passage of smoke in the event of a fire in one (1) of four (4) observations at 1:45 PM on February 25, 2014. B. The entrance door to the Multi Purpose Room on Unit 2 South was impeded from closing when the Storage Room door was in the open position in one (1) of three (3) observations at 1:35 PM on February 25, 2014. Third Floor Double swinging fire doors located at the entrance to Unit 3 South from Unit 3 North failed to close and latch into the frame in one (1) of two (2) observations at 3:25 PM on February 25, 2014. Fourth Floor A. The entrance door to room 424 on Unit 4 North was impeded from closing when the bathroom door was in the open position in one (1) of 16 observations at 4:10 PM on February 25, 2014. Fifth Floor B. The entrance doors to Room 505 was impeded from closing when the bathroom door was in the open position, this finding was observed between 4:20 PM and 5:30 PM on February 25, 2014	K 018	K025 1.Identified penetrations observed during survey tour located in the, A.The basement 3feet/4feet in B storage were repaired on 2/29/14. B.Medical records wall was repaired on 3/1/14. C.The 2inch penetration by classroom door were repaired on 2/25/14. D.The 1-2 inch hole observed around the linen chute in basement was repaired on 2/25/14. E.The 1-2 inch hole was observed in the housekeeping closet and were repaired on 2/25/14. F. The 2-3 inch hole by the exit door to the loading dock were repaired on 2/25/14. G.The 1-2 inch hole observed around communication wires over double doors at the entrance to dialysis were repaired on 2/25/14. H.The ceiling tiles in nourishment room on 2N missing were repaired on 2/25/14. I.The ceiling tiles in NCO had holes and were repaired on 2/25/14.	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025 SS=E	Continued From page 3 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 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, in the hallways and common areas which would not prevent the passage of smoke in the event of a fire in five 15 of 15 observations on February 25, 2014. These findings were observed in the presence of the Maintenance Director and the Assistant Maintenance Director. The findings include: Penetrations were observed in wall surfaces above ceiling tiles in the hallways and common areas which would not prevent the passage of smoke in the event of a fire. Basement A. Penetrations approximately 3 feet x 4 feet	K 025	2. All residents have the potential to be affected by this deficient practice. Engineering staff will conduct a facility wide inspection to ensure that there are no more penetrations in smoke barrier walls and there are no new areas identified. 3. Engineering staff will be in-serviced on life safety code standards in regards to fire wall and a penetration free environment. 4. Engineering Director/Designee will conduct monthly rounds to ensure compliance on smoke barrier walls to ensure that there are no penetration and report all findings to QAPI committee for follow up and recommendations.5/13/14	

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K 025	Continued From page 4 were observed along walls around large plumbing pipes approximately 6 inches in diameter in the Large Storage Room. Walls were not complete between the floor and ceiling in the Large Storage Room. Walls were not complete between the Large Storage Room and Storage Room B, approximately; 2 feet of wall space was open between the wall and the ceiling in three (3) of three (3) observations between 11:40 AM and 11:50 AM on February 25, 2014. B. Penetrations, approximately 2 inches in diameter, were observed around bundled communication wires and around BX Cables in wall surfaces near the Classroom in two (2) of two (2) observations at 11:55 AM on February 25, 2014. C. Penetrations, approximately 1-2 inches were observed around the circumference of the Soiled Linen Chute in the Soiled Linen Room in two (2) of two (2) observations at 12:20 PM on February 25, 2014. D. Penetrations, approximately 1-2 inches were observed in wall surfaces in the Housekeeping Closet on the Lower Level in one (1) of one (1) observation at 12:25 PM on February 25, 2014. First Floor A. A 2-3 inch penetration was observed in wall surfaces above the exit door to the Loading Dock Area in one (1) of one (1) observation at 12:30 PM on February 25, 2013. B. A 1-2 inch penetration was observed around communication wires over double doors at the	K 025		

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K 025	Continued From page 5 entrance to the Dialysis Department in one (1) of one (1) observation at 1:05 PM on February 25, 2014. Second Floor Ceiling tiles approximately 24 inches x 36 inches were missing in the Nourishment Room over the stationary cabinet in the 2 North Nourishment Room in one (1) of one (1) observation at 1:30 PM on February 25, 2014. Third Floor Ceiling tiles in the Nurse Coordinators Office were observed to have penetrations in four (4) of four (4) observations on Unit 3 South at 3:30 PM on February 25, 2014.	K 025		
K 048 SS=E	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 written plans with diagrams were not posted on walls in the Lower Level of the facility to direct staff and residents to the nearest exit in the event of a fire in three (3) of three (3 observations. The findings include: During a tour of the Lower Level of the facility, it was determined that Evacuation Routes were not	K 048	K048 1.Basement emergency exit plans were replaced and hung on 2/26/14. 2. Engineering staff will conduct a facility wide inspection to ensure that there are emergency exit plans placed around all corridors and there are no new areas identified. All residents have the potential to be affected by this deficient practice. 3. Engineering staff will be in serviced on life safety code standards in regards to evacuation plans and the importance of the plans being posted. 4. Engineering Director/Designees will conduct monthly rounds to ensure compliance on evacuation plans that they are hanging in the correct areas and report all findings to the QAPI committee for follow up.	5/13/14

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K 048	Continued From page 6 posted on walls in the hallways to identify your location (You Are Here), the location of the nearest pull station, the location nearest fire extinguisher and directions to the nearest exit. Written evacuation plans were missing throughout the Lower Level in three (3) of three (3) hallway observations at approximately 12:50 PM on February 25, 2014.	K 048	K050 1. The facility is unable to retrospectively correct deficient practice. As this was done during the first quarter on the second and third shifts. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Engineering established a new fire drill schedule and re-educated staff to ensure 4 drills will be conducted on all shifts. The Director will conduct a monthly audit of the facility's fire drill log moving forward. The Director of Engineering will monitor the new schedule to ensure compliance with scheduled drills. 4. The Director of Engineering will report any negative findings to the Administrator immediately. All findings will be reported to the QAPI Committee for follow up.	5/13/14
K 050 SS=E	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 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that documentation was not available to substantiate that Fire Drills are conducted at least quarterly on each shift in four (4) of 12 observations. This finding was observed in the presence of the Maintenance Director and the Assistant Director. The findings include: Through observation and a review of the Fire Drill Log; it was determined that documentation was not available to determine if fire drills were conducted at least quarterly on each shift. Staff	K 050		

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K 050	Continued From page 7 failed to consistently document the dates and times during each quarter on each shift; during the First Quarter on the 2nd and 3rd Shifts; Second Quarter during the 3rd Shift and Third Quarter during the 3rd Shift in four (4) of 12 observations at approximately 7 PM on February 25, 2014.	K 050	K052 1A.The facility is unable to retrospectively provide fire alarm reports for dates mentioned. B.Smoke detector was installed and repaired on 2/25/14. C.There are no sprinklers under the overhang on the exterior of the facility but it will be repaired and fixed on 6/25/14. D.The signaling devices found not to be operating when alarm was tested on April 1, 2013 will be repaired on 5/25/13. 2A.Engineering Director will monitor the completion of facility quarterly fire alarm device inspections and testing reports. B.Engineering Director will have a licensed contractor install devices. C.The facility will have the alarm company monitor code updates on sprinkler system to ensure the facility is in compliance at all times. D.Alarm Company will provide a report on all devices not functioning during the test. All residents have the potential to be affected by this deficient practice. 3. Engineering staff will be in serviced on the fire alarm system inceptions and testing form documentation. 4. Director of Engineering will report any negative findings to the Administrator immediately. All findings will be reported to the QAPI Committee for follow-up and recommendations.	6/25/14
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: A. Based on observations during the Life Safety Code Inspection, it was determined that electronic alarm devices were not tested and maintained on a quarterly basis as required in three (3) of four (4) observations. The findings include: Through observation, interview and a review of Fire Alarm Device Testing and Maintenance Reports for 2013; it was determined that documentation was not available to show that	K 052		

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K 052	Continued From page 8 alarm devices were tested and serviced on a quarterly basis as required. Documentation was provided for testing done on April 1, 2013 for the Second Quarter; however documentation was not provided to show that testing and maintenance was done between July and September 2013 and October 2013 and December 2013 in three (3) of four (4) observations at 5:55 PM on February 25, 2014. B. Based on observations during the Life safety Code Inspection, it was determined that Smoke Detectors connected to the Fire Alarm System were installed in the elevator pit by non- qualified service personnel in one (1) of one (1) observation. This finding was determined in the presence of the Maintenance Director. The findings include: Through observation, interview of Maintenance Personnel, it was determined that a defective Smoke Detector was installed in the Elevator Pit by non licensed facility personnel on February 25, 2014, to correct a trouble code that was showing on the Fire Panel. however the Fire Panel continued to show a trouble code after the Smoke Detector was installed. State and local licensure regulations shall be followed to determine qualified personnel in one (1) of one (1) observation at 7 PM on February 25, 2014. State and local licensure regulations stipulate that qualified personnel shall include, but are not limited to one or more of the requirements in NFPA [National Fire Protection Association] 72.10.2.2 and NFPA 72 10.4.3 Inspection, Testing and Maintenance Personnel.	K 052		

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K 052	Continued From page 9 C. Based on observations during the Life Safety Code Inspection it was determined that sprinklers were not installed under roofs at the front entrance and under the loading dock roof in the rear of the building in two (2) of two (2) observations. The findings include: Through observations and interview it was determined that the facility failed to meet the requirement that all Nursing Homes must be fully sprinkled as of August 13, 2013; in order to participated in the Medicare or Medicaid Programs. The final rule was published on August 8, 2008, the final rule entitled Medicare and Medicaid Programs: Fire Safety Requirements for Long Term Care Facilities, Automated Sprinkler System. The facility failed to meet the requirement as stated in NFPA[National Fire Protection Association] 13-4-1.1 which states that " a building protected by an automatic system instillation shall be provided with sprinklers in all areas where specific section of the standard permit the omission of sprinklers " in Section 5-13.8.1 and NFPA 13 8-1.1 Basic Requirements. It was determined that sprinklers were not installed under the roof at the Front Entrance of the building and under the roof in the rear Loading Dock Area of the building. Section 15-13.8.1 requires that sprinklers be installed under exterior roofs exceeding 4 feet in two (2) of two (2) observations between 2:30 PM and 3:15 PM on March 6, 2014. D. Based on observations during the Life Safety Code Inspection, it was determined that various	K 052		

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K 052	Continued From page 10 alarms and signaling devices failed to operate during the annual test and documentation was not available to show that faulty alarm devices were repaired in a timely manner. The findings include: Through observation and interview it was determined that various Signaling Devices failed to function properly during the Annual Fire Alarm Testing on April 1, 2014. The failed devices are listed on the Annual Fire Alarm Test Report from April 1, 2013. Documentation was not available during the survey and after the survey to substantiate that Fire Alarm Devices were repaired and in good working order. The following devices or parts on the Fire Alarm Inspection Report failed to function or were described as missing during the inspection: Smoke Detector 2-52 1st Floor Tamper, causes Supervisory Condition; manual Station 2-18 Hallway Classroom Boiler Room Lower Level: Manual Station 2-21 Hallway Classroom Lower Level, Glass Rod Missing; Manual Station 1-6 North Star 5th Floor, set screw missing; Manual Station 1-01 Near Room 506 5th Floor, set screw missing; Manual Station Near Room 506 5th Floor, set screw and glass rod missing and needs a new cover, Manual Station 1-2 Room 534 5th Floor; manual Station cover sounder inoperative; Manual Station 1-4 near Room 524 5th Floor, Glass rod missing and cover sounder inoperative; Manual Station 1-7 Near Room 516 5th Floor; set screw and glass rod missing; Manual Station 1-3 South Stair 5th Floor, set screw and glass rod missing.	K 052		

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K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. Based on observations during the Life Safety Code Inspection, it was determined that Housekeeping and Maintenance services were not adequate to ensure that the facility is maintained in a safe and sanitary manner; as evidenced by clothing on floor surfaces and the interior areas of exhaust vents were soiled with dust in seven (7) of 31 observations. The findings include: 1. During a tour of the facility it was determined that boxes of supplies and clothing were improperly stored on floor surfaces in the following areas: Laundry Storage Room Lower Level, 2 North and 2 South Storage Rooms in three (3) of 10 observations between 11:40 AM and 1:15 PM on February 25, 2014. 2. The interior surfaces of exhaust vents were soiled with dust in resident ' s rooms and common areas in the following areas: Main Laundry soiled side, 3 South Soiled Supply Room, 3 South Storage Room and 5 North Storage Room in four (4) of 21 observations between 11:40 AM and 4:40 PM on February 25, 2014. B. Based on observations during the Life Safety Code Inspection it was determined that a Helium Tank was not secured to prevent accidental tip	K 130	K130 1A. The clothing on the floor was removed on 2/26/14. B.The vents were cleaned on 2/27/14. C.The large tank of helium was put into a holder on 2/25/14. D.The nourishment room on 3S that was hot was fixed on 2/25/14. We have American Mechanical Services trouble shooting the AC for that room. 2. Engineering Director will conduct monthly rounds to ensure life safety codes comply with regulatory standards for the vents, storerooms, helium tanks and maintain proper room temperatures 71-81F. All residents have the potential to be affected by this deficient practice. 3. Engineering staff will be in serviced on the importance of monitoring these deficiencies as well as ambient room temps. 4. Director of Engineering will continue to monitor monthly and report all negative findings to the QAPI Committee for follow-up and recommendations.	5/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/25/2014

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K 130	Continued From page 12 over in one (1) of one (1) observation. The findings include: A large tank of Helium observed in the hallway outside of the Central Supply Room on the First Floor was not secured by a rack or chains to prevent accidental tip over, which could be potentially hazardous to staff and residents in one (1) of one (1) observation at approximately 1:30 PM on February 25, 2014. C. Based on observations during the Life Safety Code Inspection it was determined that the ambient air temperature in the Nourishment Room on Unit 3 South was elevated and presented a Fire and safety hazard to staff and residents in one (1) of one (1) observation. The findings include: During a tour of the Nourishment Area on Unit 3 South it was determined that the ambient air temperature in the 3 South Nourishment Room was 107 degrees Fahrenheit, which is above the recommended temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit in common areas for Nursing Homes. This condition presented a fire and safety hazard to residents and staff on Unit 3 South and the remainder of the facility in one (1) of one (1) observation at approximately 3:00PM on February 24, 2014. A secondary observation of the nourishment room following intervention by facility staff determined ambient temperature of 78 degrees.	K 130		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144	K144 1. Documentation is available on log sheets to show that generators are exercised under load each month for at least 30 min per Engineers log. The start and end times of the generator odometer readings do substantiate that generators operate and exercise under load for 30 min.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/25/2014

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K 144	Continued From page 13 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observations, interviews and a review of the Log Books during the Life Safety Code Inspection, it was determined that the Emergency Generator was not exercised under load for 30 minutes in six (6) of 12 observations. This finding was discussed in the presence of the Director of Maintenance and Assistant Maintenance Director. The findings include: Through observation and a review of the Emergency Generator Log it was determined that the Emergency Generator was not exercised each month for 30 minutes as required, in one (1) of one (1) observation at 7:30 PM on February 25, 2014. The Emergency Generator was not exercised under load for 30 minutes each month as required: as evidenced by the lack of documentation to support monthly exercises in the Generator Log Book. The documentation provided failed to provide the start and end times of exercises during the months of March 2013, April 2013, May 2013, June 2013 and November	K 144	2. Engineering Director will monitor the documentation for the load test for compliance of at least 30 min . 3. Engineering staff will be in-serviced on life safety code standards in regards to the generators operating and exercise under load for 30 min. 4. Director of Engineering will report any negative findings to the Administrator immediately. All findings will be reported to the QAPI Committee for follow-up and recommendations.	5/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 14 2013, exercises were not recorded to show that the Emergency Generator was exercised for 30 minutes each month in five (5) of 12 observations at 7:30 PM February 25, 2013.	K 144		