STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2007

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CAPITOL HILL NURSING CENTER	700 CONST. AVE. NE WASHINGTON, DC 20002

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K 000	INITIAL COMMENTS The annual Life Safety Code inspection was conducted on August 1, 2007. The following deficiencies were cited based on observations and staff interviews.	K 000	K017-1,2,3 **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The penetrations noted that were 2-3 inches on level A basement, around metal pipe and communication wires near room 4144, and around wires in walls above double doors 5128, 6166, 6127, and 6144 were all repaired on Sept 5, 2007. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the nursing center were inspected for penetrations and no other areas found. No other residents were affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Whenever contractors come into the building to do work the engineering supervisor will ensure no penetrations as a result of the work done by inspecting their work prior to completion. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** The engineering supervisor will do rounds conduct inspections after contractors and report all deficient findings to the monthly QA meeting.	
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that penetrations were in wall surfaces above ceiling tiles. These findings were acknowledged by Employee #18 at the time of the observations. The findings include: 1. Penetrations approximately 2-3 inches, were observed on the A level (basement) around a	K 017		9/27/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lane Marie Cullen	Administrator	9/21/07

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 rs following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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K 017	Continued From page 1 metal pipe and ductwork over door #314, wall surfaces above double doors #A401 and a large opening was observed around pipes near A201 in three (3) of three observations of wall surfaces at 3:20 PM on August 1, 2007. 2. Penetrations approximate 2-3 inches were observed around a metal pipe and communication wires near room 4144 in one (1) of seven (7) observations of wall surfaces between 3:25 PM and 3:40 PM on August 1, 2007. 3. Penetrations approximately 2-4 inches were observed around wires in walls above double doors 5128, 6116, 6127 and 6144 in four (4) of seven (7) observations of wall surfaces on August 1, 2007 between 3:43 PM and 4:30 PM.	K 017	K018 – 1, 2, 3 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The fifth floor soiled utility room door, the double smoke barrier doors near room 5144, and the resident's rooms 4105 and 5124 doors were all repaired on September 5, 2007. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other doors in the nursing center were inspected for not latching and failing to close. No other doors were found to have this deficiency. No other residents affected by this deficient practice. 3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All doors will be inspected and tested on a routine basis by maintenance staff. Engineering supervisor will conduct rounds weekly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** Engineering supervisor will report all deficient practices at the monthly QA meeting.	9/27/07
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.	K 018		

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection, it was determined that doors failed to close and latch when tested. These findings were acknowledged by Employee #18 at the time of the observations. The findings include: 1. The fifth floor soiled utility room door failed to close and latch when tested in one (1) of one (1) door observed at approximately 3:00 PM on August 1, 2007. 2. Double smoke barrier doors near room 5144 failed to close without assistance in one (1) of five (5) door observations at 3:10 PM on August 1, 2007. 3. Residents' rooms 4105 and 5124 doors failed to latch when tested in two (2) of 10 doors observed between 2:45 PM and 3: 30 PM on August 1, 2007.	K 018	K045 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The bulbs in stairwell #9, fourth floor, stairwell #9, fifth floor, stairwell #8, sixth floor, and stairwell #9 sixth floor were all changed immediately. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the nursing center were inspected for bulbs burned out. No other areas were found. No other residents affected by this deficient practice. 3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Stairwells will be inspected during weekly rounds by engineering supervisor. All staff educated about reporting to maintenance whenever they note bulbs go out throughout the facility. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** Engineering supervisor will conduct rounds weekly and report all deficient practices to monthly Quality Assurance meetings.	9/27/07
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045		

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K 045	Continued From page 3 Based on observations during the Life Safety Code inspection, it was determined that bulbs were not lit to provide illumination in the stair well. This finding was acknowledged by Employee #18 at the time of the observation. The findings include: Light bulbs in the stairwells were not lit to provide illumination in Stairwell #9, fourth floor; stairwell #9, fifth floor; stairwell #8, sixth floor; and stairwell #9 sixth floor in four (4) of six (6) stairwell observations between 2:30 PM and 4:10 PM on August 1, 2007.	K 045	**K047** **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The bulbs in the fixtures of the exit and directional signs were all replaced immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the nursing center were inspected bulbs burned out in exit signs. No other areas were found. No other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The engineering staffs were all in-serviced and educated on conducting routine PM on September 24, 2007. The engineering supervisor will conduct rounds weekly to monitor. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** The engineering supervisor will monitor and report all deficient practices to the monthly QA meeting.	Sept 27,2007
K 047 SS=D	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 observations during the Life Safety Code inspection, it was determined that exit and directional signs were not illuminated. This finding was acknowledged in the presence of Employee #18 at the time of the observation. The findings include: Exit and directional signs were not illuminated in the hallways near rooms 4116 and 5144 in two (2) of eight (8) exit/directional sign observations between 2:45 PM and 4:10 PM on August 1, 2007.	K 047		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052 SS=E	Continued From page 4 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: Based on observation during the Life Safety Code inspection, it was determined that the fire alarm system was not maintained and serviced on a regular basis. This finding was acknowledged in the presence of Employee #18 at the time of the observation. The findings include: According to the June 13, 2007 fire inspection: 1. The batteries located on the inside of the fire alarm panel on the B level failed the load test and should be replaced" Simplex (2081-9272) 2. The batteries located inside of two (2) transformer panels on the B level failed and both need to be replaced" Simplex (2081-9275) 3. The batteries in the A level inside panel 4100 panel inside of the switch gear room failed the load test and need to be replaced.	K 052	K052 – 1, 2, 3, 4, 5, 6 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All the batteries located on the inside of the fire alarm panels, transformer panels, and transponder on A and B level that were dead or corroded will be placed by the service company on September 15, 2007. Dead batteries affected the transponders for the entire system. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All panels tested failed. All residents have the potential to be affected by this deficient practice. 3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Engineering supervisor will continue quarterly testing of the entire fire alarm and suppression system. The Service company will check batteries quarterly and change as needed. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** The Engineering supervisor will report all finding at the monthly QA meeting.	9/27/07

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K 052	Continued From page 5 4. The batteries for transponder 104, 106, and 109 failed the load test or the battery leads were corroded. (Simplex 208109275 and Simplex 2081-9274) 5. The following test failed (during the June 13, 2007 inspection): Control Panel Multiplex, Control Panel Basic Multiplex, Display Terminal w/Keyboard, Duct Smoke Test, Multiplex Transponder and Battery Leads were corroded, Speaker Control Device." 6. The following test failed during the June 13, 2007 inspection: Control Panel Multiplex, Control Panel Basic Multiplex, Display Terminal w/Keyboard, Duct Smoke Test, Multiplex Transponder and Battery Leads were corroded and the Speaker Control Device was missing The fire inspection report was reviewed between 2:00 PM and 3:00 PM on August 1, 2007. Documentation was not available during the survey to substantiate that the aforementioned fire alarm system deficiencies were corrected or that the system had been tested since the June 13, 2007 fire inspection.	K 052		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on record review during the Life Safety Code inspection, it was determined that facility staff failed to consistently record the start and end times for exercising the generator under full load	K 130		

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K 130	Continued From page 6 The findings include: During a record review of the emergency generator logs, it was determined that the odometer start and end time for generators #1, #2, #3 and #5 were not recorded to substantiate that each generator was exercised at least thirty minutes per month under load on the following dates: January 5, 2007, no start and end times for generators #1 and #2. February 23, 2007, no start and end times for generators #3 and #5. March 2, 2007, no end time for generators #1 and #3. This observation was made in the presence of Employee #18, who acknowledged that the start and end times were not consistently recorded in six (6) of 14 generator logs reviewed on August 1, 2007.	K 130	K130 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The start and end times of the emergency generators were not consistently recorded. No retrospective changes can be made. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A review of all other start and end times did not reveal additional deficient practice. No residents were affected by this deficient practice. 3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Engineering supervisor did educate the staff on the importance of appropriate start and end times documentation for all generators during load tests. The engineering supervisor will be monitoring to ensure correct times are logged. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place?** The engineering supervisor will do monthly audits and report any deficient practices to the monthly QA committee.	9/27/07