STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(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 Life Safety Code Inspection was conducted in your facility on May 24, 2010, the following deficiencies were cited.	K 000	The Washington Center for Aging Services makes its best efforts to operate in substantial compliance with both Federal and State Law. Submission of this Plan of Correction 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 alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law.	
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 double and single doors failed to close and latch into frames when tested in five (5) of 16 observations and privacy curtains and curtain mesh surfaces could potentially prevent resident doors from closing during an emergency in four (4) of 18 observations. These finding were observed in the presence of employee # 4.	K 018	1.All the curtains that are fully extended in the resident's rooms were checked and corrected immediately to insure that door would close completely without the curtains profiting door from closing in an expeditious manner. No resident was affected by this practice. 2. Inspection of all facility residents' curtains and the doors were conducted, no other door was found to be affected by this practice. 3. The maintenance staff were reeducated on safe operation of fire doors in the rooms and the curtains. Maintenance staff will monitor and inspect the safe operation of all fire doors in the facility once a month. 4. The director of Engineering or the assistant director of Engineering will make random Inspection on doors and curtains monthly. the findings will be reported to the QA committee quarterly.	6/25/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Torino	Administrator	06/25/2010

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
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(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 1 The findings include: Three Green 1. The Nourishment Room door # A392F was damaged and difficult to open and close when examined in (1) of one (1) observation at approximately 2:05 PM on May 24, 2010. 2. Double doors located at the entrance to the Solarium failed to close and latch into frames when tested in one (1) of one (1) observation at 2:10 PM on May 24, 2010. Two Blue 3. The SPA door failed to close and latch into the frame in one (1) of one (1) observation at 2:40 PM on May 24, 2010. One Green 4. The Nourishment Room door # A192 failed to latch into the frame when tested in one (1) of one (1) observation at 3:45 PM on May 24, 2010. One Orange 5. Double fire doors located near the Nurses Station failed to latch into the frame when tested in one (1) of two (2) observations at 4:30 PM on May 24, 2010. 6. The Men ' s Bathroom door # C125 failed to close and latch into the frame when tested in one (1) of two (2) observations at 3:50 PM on May 24, 2010.	K 018	1.The nourishment room doors #392 & #192 the double doors at entrance to solarium, the spa door, and the double near the nurses station, the men's bathroom door #C125 have been corrected to ensure that they close and latch. No resident was affected by this practice. 2.An inspection of all fire doors was conducted to ensure that they close and positive latching was maintained. Corrections were made if indicated. 3.The director of Engineering conducted a meeting and in-service with staff to review the importance of checking doors to ensure accessibility at all times. 4.The Director of Engineering reviewed the preventive maintenance program to ensure that the operation and inspection of doors are conducted monthly. The findings are reported in the QI meetings.	6/25/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(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 2 One Blue 7. The inner door nearest the stairwell failed to close and latch into the frame when tested at 5:25 PM on April 24, 2010 in one (1) of three (3) observations. 8. The entrance door to room # 105 was difficult to close and open without assistance and was observed to be warped or damaged in one (1) of five (5) observations at 5:35 PM on April 24, 2010. 9. When privacy curtains are fully extended in residents rooms, it was determined that resident entrance doors could be prohibited from closing as the curtains are drawn towards the door and the mesh surfaces of curtains could potentially become entangled when doors are in the process of closing in an expeditious manner in the following areas; Rooms 306, 307 and 313 on Unit Three Blue and room 316 Unit Three Orange in four (4) of 18 observations between 1:50 PM and 5:40 PM on May 14, 2010.	K 018	1.The inner door nearest the stairwell, and the entrance door to room #105. have been corrected to ensure that they close and latch. No resident was affected by this practice. 2.An inspection of all fire doors was conducted to ensure that they close and positive latching was maintained. Corrections were made if indicated. 3.The director of Engineering conducted a meeting and in-service with staff to review the importance of checking doors to ensure Accessibility at all times. 4.The Director of Engineering reviewed the preventive maintenance program to ensure that the operation and inspection of doors are conducted monthly. The findings are reported in the QI meetings quarterly.	6/25/10
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and interview during the Life Safety Code survey it was determined that documentation was not available to substantiate which floor elevators are assigned to report to in the event of an emergency in one (1) of one (1) observation and through observation during the Fire Alarm Test it was determined that elevators	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(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 3 failed to report to predestinated areas in two (2) of five (5) observations. The findings include: 1. During the Life Safety Code Inspection it was determined through observation and interview that documentation was not available to substantiate to the surveyors which floor each elevators are assigned or programmed to report in the event of an emergency. Facility staff verbally indicated that elevators are programmed to report to the basement when the fire alarm system is activated however elevators failed to report to pre assigned floors during the Fire Alarm Test in one (1) of one (1) observation during a review between 11:30 AM and 12:30 PM on May 24,2010. 2. The Pull Station was activated during a Fire Alarm Test on Unit Two Orange near the center of the building, double and single doors closed properly; the center elevator was manually called to the third floor, the elevator reported to the third floor and remained on the third floor, documentation was not available to substantiate why the elevator remained on the third floor instead of reporting to the basement. The second test was conducted by activating the Pull Station near the Nurse Station on Unit Two Orange, double and single doors closed properly as required; the elevator reported to the first floor instead of the basement level as facility staff stated, documentation was not available to substantiate why the elevator reported to the first floor instead of the basement in two (2) of five (5) observations between 2:30 PM and 3:10 PM on May 24, 2010.	K 130	1. All elevators were tested for fire service recall by activating smoke detectors conducted by elevators contractors. 2. The remaining elevator were tested and They were not affected by this practice. 3.The facility will add elevator recall to Fire disaster plan policy # 58 with reeducation of the Engineering Team. 4. The Director of Engineering reviews and inspect all the elevators monthly. The findings are reported in the QA meetings quarterly. .	6/25/10