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

PRINTED: 11/02/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK MANOR NURSING CTR	2131 O STREET NW WASHINGTON, DC 20037

(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 annual Life Safety Code inspection was conducted October 24, 2007. The following deficiencies were based on observations and interviews with staff.	K 000		
K 017 SS=D	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 wall surfaces above ceiling tiles were not secured to prevent the passage of smoke in the event of a fire. These observations were made in the presence of Employee #15. The findings include: 1. Penetrations approximately 1-2 inches were	K 017	1. Smoke Penetration on the second floor was repaired on 10/25/07 and the lobby level. 2. Smoke barriers on all floors were checked and the penetrations were corrected by the Director of Maintenance to meet compliance. 3. Smoke barriers will be checked monthly during PM rounds and recorded in the PM Log Book for repairs and to ensure compliance.	Revised received 12/4/07

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 11/19/07

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

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K 017	Continued From page 1 observed around water pipes above ceiling tiles near the front desk in the lobby in three (3) three (3) observations at 3:15 PM on October 23, 2007. 2. Penetrations approximately 1-2 inches were observed in wall surfaces above ceiling tiles near rooms 202 and 208 in two (2) of seven (7) observations at 3:45 PM on October 24, 2007. Employee #15 acknowledged the above findings at the time of the observations.	K 017	4. Problems relating to smoke penetrations will be reported to the Director of Maintenance immediately and to the Administrator for remedial action and discussed in the monthly Risk Management and Quarterly QA meetings.	12/10/07
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 9.3.4, 9.6	K 051	1. Lights in North Wing Stairwells were reset on 10/24/07. 2. Lights in all stairwells were checked by the Director of Maintenance and found to be in compliance. 3. Lights in all stairwells will be checked weekly during Maintenance rounds and recorded in the Maintenance Log Book for immediate repairs.	

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code survey, it was determined that single illumination lamps were not lit to provide lighting in stairwells. These observations were made in the presence of Employee #15. The findings include: Single illumination lamps were not lit to provide lighting for staff and residents to ambulate the stairwells in the event of a fire in the following stairwells: first floor north, second floor north, third floor north, fifth floor north and fifth floor west landings in five (5) of five (5) observations between 3:15 PM and 4:25 PM on October 24, 2007. Employee #15 acknowledged the above findings at the time of the observations.	K 051	4. Problems relating to lights will be reported to the Director of Maintenance and to the Administrator for remedial action and discussed in monthly Risk Management and Quarterly QA meetings.	10/24/07
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection and the environmental tour, it was determined that facility staff failed to remove tape covering two (2) of five (5) smoke detectors. These observations were made in the presence of Employees #15 and 16. The findings include:	K 130	1. The smoke detector in the soiled utility rooms on units 4 and 5 were repaired on 10/25/07. 2. Smoke detectors on all floors in the facility were checked by the Director of Maintenance and found to be in compliance.	

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K 130	Continued From page 3 On October 24, 2007 between 9:15 AM and 11:10 AM, it was observed that the smoke detectors located in the 4th and 5th floor soiled utility rooms were covered with tape. Employee #15 stated at the time of the observation, "The facility was treated on Monday, (October 22, 2007) and the chemical used caused the smoke detectors to alarm. We covered the smoke detectors to prevent them from alarming and just missed uncovering these two (2)." Employees #15 and 16 acknowledged the above findings at the time of the observations.	K 130	3. Smoke detectors will be checked quarterly during alarm system PM's and recorded in PM log book for corrective action and to ensure compliance. 4. Problems relating to smoke alarms will be reported to the Director of Maintenance immediately and to the Administrator for remedial action and discussed in the monthly Risk Management and Quarterly QA meetings.	10/25/07