STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09E020	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	4200 HAREWOOD ROAD 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 An annual Recertification (Life Safety Code) Survey was conducted on March 29, 2011. The findings are based on observations made during an inspection of your facility.	K 000	Start Typing Here:	
K 050 SS=D	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 staff were not familiar with emergency procedures or failed to respond expediently during an unannounced test of the fire alarm system in two (2) of two (2) observations The findings include: The Fire Alarm Pull Station was manually activated near the Nurses Station on the Good Shepherd Unit, at approximately 12:05 PM, it was determined that staff were unsure of emergency procedures or failed to act in a timely manner to close doors on the north side of the unit, as evidenced by two (2) residents ' room doors that remained open during the second tour of the Unit and the Second Floor Dining Room doors on both sides of the hallway remained	K 050	1. No resident was observed or reported To have been harmed by this deficient practice. 2. Inservicing was done on the importance Of protecting the residents from any harm By educating the staff on our policies and procedures for fire and safety so that the Facility will be incompliance in following State and federal regulation and guidelines. The staff was inserviced on their roles and responsibilities in following the requirements in Fire and Safety Expediently 3. All employees will be instructed on Fire and safety procedures based on RACE (Remove, Alarm, Contain, Evacuate Extinguish) and facility's policy and Procedure. All were instructed on the importance Of closing doors including the dining room doors and moving residents from danger in an expedient manner.	

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

A. Christine Meade | Administrator | 4/20/11

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
	09E020	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	4200 HAREWOOD ROAD 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 050	Continued From page 1 open through the drill in two (2) of two (2) observations between 12:05PM and 12:15 PM on March 29, 2011.	K 050	4. Monthly fire drills will be planned in order to make sure that our facility is Incompliance with fire and safety and will be documented. Any in fractions identified will be addressed immediately and Followed up at the weekly safety meetings and quarlty QA meetings to Ensure compliance of Fire and Safety as well as quality of life Of our residents. 5. All staff was inserviced on Fire and Safety April 20, 2011. 4/20/2011 Fire drill and In Service was completed April 20, 2011. Compliance Met.	4/20/2011