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

PRINTED: 09/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095040	B. WING		08/18/2021	
NAME OF PROVIDER OR SUPPLIER THE HSC PEDIATRIC SKILLED NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1731 BUNKER HILL ROAD NE WASHINGTON, DC 20017	100/10/2021	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	HOULD BE COMPLÉTION	
E 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		E 01	1. Administrator will dev	ddress sposal. sew ness y re service vised vill review sparedness	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	

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.

Maria Allen

Administrator

10.21.21

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE	
E 015	(B) Emergency light (C) Fire detection, esystems. (D) Sewage and water *[For Inpatient Hosp Policies and proced (6) The following ar hospice-operated in policies and proced (iii) The provision of employees and patishelter in place, incomplowing: (A) Food, water, mesupplies. (B) Alternate source following: (1) Temperatures to safety and for the sprovisions. (2) Emergency light (3) Fire detection, esystems. (C) Sewage and water this REQUIREMENTAL Based on record refailed to include pol for sewage and water preparedness plan. The findings include A review of the facil plan on August 18,	extinguishing, and alarm aste disposal. Dice at §418.113(b)(6)(iii):] Ilures. e additional requirements for apatient care facilities only. The ures must address the following: f subsistence needs for hospice ents, whether they evacuate or lude, but are not limited to the edical, and pharmaceutical es of energy to maintain the edical, and sanitary storage of eing. Extinguishing, and alarm aste disposal. Note is not met as evidenced by: Eview and interview, facility staff icies and procedures to provide ste disposal in their emergency Extinguishing to disclose and procedures pertaining to	E 015	4.Administrator or designee will present review findings, revised policy/procedures to QAPI Sub-Committee for review recommendations, and approximate This will be done for one quart annually thereafter.	ew, ⁄al.	10/21/21

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E 015	Employee #1 confirr	ned the findings during a w on August 18, 2021, at	E 015				