STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 A recertification Life Safety Code inspection was conducted at your facility on August 20, 2012. An immediate jeopardy was identified (IJ) at NFPA 101 Life Safety Code Standard K051 and cross referenced to 42CFR 483.70 F454 Life Safety from Fire on August 20, 2012 at 5:58 PM. The facility's Administrator provided a letter noting a corrective action plan and the IJ was removed on August 21, 2012 at 10:10 AM. The following deficiencies are based on observations, interviews and record reviews during the survey period.	K 000	**K 017 #1** 1. All ceiling tiles that were missing or damaged were replaced. 2. A recheck was on done 9/3/12 & again on 10/2/12 to ensure all ceiling tiles were properly replaced. 3. Monthly checks of ceiling tiles will be conducted by maintenance to ensure all ceiling tiles are in place. 4. Monthly checks will be kept in a log indicating compliance with tiles being in place. If any are found to be missing, they will be replaced immediately.	8/24/12
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	K 017	**K 017 #2-4** 1. All openings and penetrations were caulked with heat resistant caulking. 2. A recheck was on done 9/3/12 & again on 10/2/12 to ensure the openings and penetrations had not reopened. 3. Monthly checks of all walls surfaces will be conducted by maintenance to ensure there are no openings and/or penetrations. 4. Monthly checks will be conducted by maintenance to ensure there are no openings or penetrations. All openings and penetrations found will be immediately addressed and corrected.	8/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/18/12

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.

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K 017	Continued From page 1 Code Inspection, it was determined that penetrations were observed in smoke barrier walls, ceiling tiles were missing and penetrations were observed around Stan pipes in the stairwells, which would not contain the passage of smoke in the event of a fire. These findings were observed in the presence of the Director of Engineering. The findings include: 1. Ceiling tiles were missing or damaged and a large opening was observed in the First Floor Soiled Utility Room, an opening was observed in the closet wall approximately 12 x 14 inches and an opening was observed around ceiling tiles in the Utility Closet and Storage Room which would not contain the passage of smoke in the event of a fire in four (4) of four (4) observations at 3:14 PM on August 20, 2012. 2. Penetrations approximately ¼ inch were observed around Standpipes that were installed in stairwells 6, 7, 8 and 9 on the First and Second Floors in eight (8) of eight (8) observations on August 20, 2012. 3. A 1-2 inch penetration was observed in wall surfaces around a BX Cable above the Lower Level and First Floor Dining Room doors in two (2) of four (4) observations at 3:30 PM on August 20, 2012. 4. Openings approximately 12 x 6 inches were observed in wall surfaces above the Lower Level Kitchen door and a 1 " opening was observed around a Sprinkler Pipe above the door on the Lower Level Unit in one (1) of two (2)	K 017	**K 017 #5** 1. A temporary piece of equipment has been attached to the doors to ensure there is a solid seal when the doors are closed. 2. To prevent this from reoccurring again, both pantry doors will be monitored by maintenance to ensure they close with a proper seal. 3. New doors have been ordered for the pantry adjacent to room 187. 4. Maintenance will monitor both sets of pantry doors on a monthly basis. Any signs of doors being out of compliance will be addressed immediately.	8/31/12

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K 017	Continued From page 2 observations at 3:40 PM on August 20, 2012. 5. Small approximately 1-2 inches in diameter were observed in wall surfaces above double doors at the entrance to the Cafeteria on the First Floor adjacent to room 187 in three (3) of three (3) observations at 305 PM on August 20, 2012.	K 017		
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 doors failed to close and latch without assistance; one (1) door was held in the open position by a wedge and resident room entrance doors were	K 018	**K 018** 1. All bathroom and entrance doors that were affected were adjusted to properly close. The wedge was removed and the affected door closure was also adjusted. 2. All resident bathroom doors have been inspected to make sure all will close and do not impede the closure of the entrance doors when the bathroom door is in the open position. 3. All maintenance staff has been inserviced to ensure all residents remain safe. 4. Bathroom doors are being monitored by maintenance to ensure all are closing properly. In addition, hinges are being replaced as needed to ensure the doors will always close.	8/24/12

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K 018	Continued From page 3 impeded from closing by bathroom doors when they were in the open position. These findings were observed in the presence of the Director of Engineering. The findings include: 1. Entrance doors to resident rooms, double doors and bathroom doors failed to close and latch into frames without assistance in rooms 070, 095, 172 173 and 175. The oxygen storage room door; the bathroom door near rooms 173 and 095; glass doors located at the entrance to the sitting area near the Cafeteria on the First Floor and double doors located at the entrance to the Kitchen on the First Floor failed to close and latch without assistance. A wooden wedge was observed holding a door open adjacent to the Nurses Office near Room 099 in ten (10) of 25 observations between 3:00 PM and 4:50 PM on August 20, 2012. 2. Bathroom doors in residents rooms failed to close and were observed to impede the closure of the entrance doors when the bathroom door was in the open position in the following rooms, 082,083, 172, 175, 183, 187, 191, 194 and 199 in (9) of 24 observations between 3:10 PM and 4:40 PM on August 20, 2012.	K 018		
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by:	K 034		

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K 034	Continued From page 4 Based on observations during the Life Safety Code Inspection, it was determined that Exits and Egress Areas were blocked in stairwell # 6 as evidenced by paint and painting supplies stored at bottom of the stairwell which could impede easy access out the building in the event of an emergency. These findings were observed in the Presence of the Director of Engineering. The findings include: The Exit and Egress Areas of stairwell # 6 were blocked with five (5), 5 gallon buckets of paint and drop cloths on the floor in the stairwell landing area which could potentially impede egress to residents and staff exiting the building in the event of a fire in one (1) of eight (8) observations at 3:45 PM on August 20, 2012.	K 034	**K 034** 1. All paint buckets and drop cloths that were blocking stairwell #6 were removed. 2. All stairwells were inspected to ensure there was nothing impeding egress to residents and staff exiting the building. 3. All housekeeping and maintenance staff have been inserviced on the importance of keeping stairwells clear. 4. All stairwells will be monitored to make sure there is no potential impede egress to residents and staff. Any such objects will be removed immediately.	8/21/12
K 045 SS=D	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: Based on observations during the Life Safety Code Inspection, it was determined that lamps in the stairwells failed to illuminate creating a potential hazard for staff and resident ' s in the event of an emergency. These findings were observed in the presence of the Director of Engineering.	K 045		

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K 045	Continued From page 5 The findings include: Lamps located in the stairwells failed to provide illumination during the survey, creating a potential hazard in the event of a fire or natural emergency, in stairwells # 6 and # 9 in the First Floor and Lower Level stairwells in four (4) of eight (8) observations between 3:10 PM an 4:32 PM on August 20, 2012.	K 045	**K 045** 1. Bulbs for the lamps that failed to provide illumination during survey were replaced. 2. All lamps in all stairwells were checked to ensure proper illumination. 3. Maintenance and housekeeping staff were inserviced on making sure any potential safety hazard involving lamps with no illumination be reported directly to the Facilities office. 4. Maintenance will check all stairwell lamps weekly to make sure they are properly illuminated.	8/22/12
K 051 SS=L	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. 19.3.4, 9.6	K 051		

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K 051	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations, staff interview and record review during the Life Safety Code Survey conducted on August 20, 2012 from 3:00 PM through 7:30 PM, it was determined that the fire alarm system failed to annunciate a signal when manual pull stations were activated on each floor of the Health Unit in eight (8) of eight (8) observations. The findings include: The fire alarm system failed to annunciate a signal throughout the facility when the manual pull station levers were pulled to activate the system inside and outside of Stairwells #6, 7, 8 and 9 near the elevator on the lower level on August 20, 2012 at approximately 4:30 PM. A second fire alarm test was conducted on the first floor (upper level) at Stairwell #6, 7, 8 and 9 on August 20, 2012 at approximately 4:45 PM, the system was activated by pulling the lever on the manual pull station and failed to illicit an audible response. A third test was conducted on August 20, 2012 at approximately 5:00 PM at each of the pull stations in both the upper and lower nursing units of the Health Center and there was no audible signal elicited from the manual initiation. The facility Administrator was notified regarding the lack of audible alerts when the fire pull stations were activated. An Immediate Jeopardy was identified by the Department of Health at 5:58 PM on August 20, 2012.	K 051	**K051** 1. Immediately after meeting with the surveyors about the fire alarm systems at 5:58 p.m. on 8/20/12, a smoke watch plan was developed in accordance with the D.C Fire Marshall's Administrative Directive 03-2009. The plan was accepted by the surveyors at approximately 8:30 p.m. on 8/20/12 as being appropriate and was implemented at that time. All staff were inserviced about the smoke watch plan commencing with the 3-11 p.m. shift on 8/20/12 and ending with the 7 am -3 9m shift on 8/21/12. At 8:01 a.m. on 8/21/12 when the Fire Marshall's office opened, a call was placed to them in accordance with the D.C. Fire Marshall's Administrative Directive 03-2009. We received permission to fax the plan to their office that had been implemented 12 hours ago on 8/20/12. *(See attached plan).* The plan was accepted by the Fire Marshall at 10:10 a.m. on 8/21/12. On 8/21/12 at 8:45 a.m. the contractor who services the fire alarm system was contacted about the pull station issues. At 9:59 a.m. he responded via email *(see attachment)* that a technician was enroute to Ingleside to diagnose and resolve the problems with the fire alarm system. A request to rescind the smoke watch was sent to the Fire Marshall at 4:11 p.m. on 8/24/12 as the system was back in working order. At 1:15 p.m. on 8/27/12, the Fire Marshall cancelled the fire watch as the system was in working order.	8/20/12 8/20/12 8/21/12 8/24/12

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K 051	Continued From page 7 In response to the aforementioned notification, the facility Administrator acknowledged an awareness of a malfunction in the fire system and stated that a "Smoke Watch "plan had been implemented. However, there was no evidence that the facility Administrator was aware that the alarm pull stations were inoperable (lack of audible alerts). The Administrator was not able to provide documented evidence of the actual date that the "Smoke Watch " plan had been initiated nor written evidence of the plan. According to interview with the facility Administrator on August 20, 2012 at 5:30PM, the smoke watch plan included facility security staff making rounds (frequency not defined) throughout the building looking for smoke. Further, the "Smoke Watch" plan had not been approved by the District of Columbia Fire Marshall, nor had the State Agency been notified regarding the circumstances. On August 20, 2012, the facility administrator developed a " Fire-Watch " [note: " Smoke Watch "is a term used by the facility and " Fire Watch "is a term used by the D.C. Fire Department, however, both are used interchangeably] plan to monitor the building on an hourly basis and staff were in-serviced, e.g. regarding the need to call 911 in the event of fire and locations of extinguishers. The survey team reviewed and accepted a corrective action plan prior to departing the facility on August 20, 2012. Subsequently, the facility implemented their corrective action plan. The facility's Administrator contacted the Fire Marshall and submitted a Fire Plan, which was approved on August 21, 2012 at 10:09 AM. The Immediate Jeopardy was lifted at 10:10 AM on August 21, 2012.	K 051	**F051** 2. If an issue occurs with the fire alarm system in the future, the proper corrective actions will be put into place. This will include the possibility of a new smoke watch (in accordance with Fire Marshall's Administrative Directive 03-2009), contacting the contractor to repair the system, informing staff of any plan that has been put into place and inservicing staff about proper safety measures to ensure that residents are safe until the issue is resolved. 3. The fire alarm system is in good functioning order but was installed in the 1960's. To ensure that residents remain safe, a new fire alarm system is being installed *(see attachment)*. This will take several months to complete the installation. Once the new system has been approved by the Fire Marshall and the DCRA office it will become operational. 4. To ensure that the fire alarm system is properly working, the facility will continue to conduct the required fire drills on all three shifts as well as continue to have the contractor do the quarterly testing of the system. Staff will also continue to have the inservices about fire safety. If any problem occurs with the system it will be immediately reported to the contractor to fix.	

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K 051	Continued From page 8 After a review of the accepted Fire Watch plan by the Fire Marshall, it was determined that the deficient practice was lowered to a scope and severity of " F " . 2. Based on observations on August 20, 2012 and through staff interview, the facility's annunciator panel displayed a "trouble signal" (trouble code lamp was illuminated) indicating a malfunction within the facility's fire alarm system. The findings include: An interview with Employee #5 was conducted on August 20, 2012 at 3:00 PM. He/she acknowledged an awareness of a problem with the annunciator panel and that the annunciator trouble code lamp displayed a "trouble signal ". The employee stated that a contract technician had been to the facility on more than one occasion to service the system, but the repair had not been completed. On August 21, 2012, the facility's contracted technician was onsite to repair the system and Fire Inspectors from the District ' s Fire & EMS Division concurred that the safety measures in place were appropriate.	K 051		