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 _____	**08/31/2015**

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 The following findings are based on observations, record review and staff interview during the Life Safety Code survey conducted on August 31, 2015.	K 000		
K 018 SS=D	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 entrance doors failed to close and latch into frames when tested in four (4) of seven (7) observations. These findings were observed in the presence of the Maintenance Director.	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ann R. Schoff TITLE: Administrator (X6) DATE: 10/16/2015

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
	095028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/31/2015**

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 018	Continued From page 1 The findings include: 1. Double doors located at the entrance to the Day Room near the Nurses Station in the First Floor Health Center failed to close and latch into frames without assistance when tested in one (1) of four (4) observations at 10:00 AM on August 31, 2015. 2. The bathroom entrance door in resident room 070 failed to failed to close and latch into the frame when tested in one (1) of one (1) observation at 9:55 AM on August 31, 2010. 3. Pantry entrance doors on the Lower Level and First Floors were difficult to close failed and latch into door frames when tested in two (2) of two (2) observations between 9:50 AM and 11:00 AM on August 31, 2015.	K 018	**K018** 1. The findings on the double doors at the entrance of the day room near the nurses station on the first floor, the bathroom entrance door in resident 070, and the pantry entrance doors on the lower level were all addressed and are now functioning within code. 2. All other doors in resident areas were checked and they are within fire and safety code. No residents were affected. 3. Maintenance department will be in-serviced on first safety codes for doors. 4. The Director of Facilities or designee will do monthly inspections of doors to ensure proper closure. Any and all findings will be immediately fixed. All findings will be brought to Safety Committee and to the QA committee for review and action.	9/15/2015 9/15/2015 9/30/2015
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations during the Life Safety	K 025		

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 _____	**08/31/2015**

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 025	Continued From page 2 Code Inspection, conducted on August 31, 2015, it was determined that the facility failed to ensure that smoke barrier walls were secured to prevent the passage of smoke in the event of a fire as evidenced by the observation of penetrations in nine (9) of 11 observations. These findings were observed and acknowledged in the presence of the Maintenance Director. The findings include: During a tour of the Health Care Unit, it was determined that penetrations were observed in wall surfaces above ceiling tiles and around sprinkler heads and escutcheon rings in the following areas. 1. A 1 inch penetration was observed around the sprinkler and escutcheon ring in the Lower Level Linen Room in one (1) of one (1) observation at 9:30 AM on August 31, 2015. 2. A 12 " X 12 " inch opening was observed in the Lower Level Bathroom Ante Room ceiling in one (1) of two (2) observations at 9:40 AM on August 31, 2015. 3. A 1-2 inch penetration was observed around the sprinkler and ceiling tiles in one (1) of one (1) observation and four (4) of four (4) penetrations were observed around copper pipe that pass through walls surfaces in the Lower Level Bathroom and Ante Room adjacent to the Pantry Room. 4. A 1-2 inch penetration was observed around the sprinkler escutcheon ring and ceiling tile in the Upper Level Biohazard Room in one (1) of one (1) observation at 10:30 AM on August 31,	K 025	**K025** 1. All identified penetrations in ceiling tiles were fixed and are now within code. 2. Faculty wide inspection of ceilings was done; no other penetrations were observed. No resident was affected. 3. Facility Department employees and contractors will be educated on safety code regarding penetrations. The Facility Director or Designee will inspect all work after completion to ensure compliance. 4. Facility Department will do quarterly inspections of ceiling tiles to ensure no penetrations. Any discrepancies will be fixed immediately. Finding will be reported to the Safety Committee and to the QA committee for review and action.	9/15/2015 9/15/2015 9/15/2015

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 _____	**08/31/2015**

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 025	Continued From page 3 2015. 5. A 1-2 inch penetration was observed around the escutcheon ring and ceiling tiles in one (1) of one (1) observation and a 1 inch penetration was observed around copper pipe passing through the Lower Level Bathroom Ante Room wall to the Pantry Room in one (1) of one (1) observation at 10:40 AM on August 31, 2015.	K 025	**F056** 1. The requested report was not available from the service company. 2. No residents were affected. 3. The service company was educated on code NFPA25 and required documentation. All documents will be forwarded to Maintenance Supervisor quarterly. 4. The Director of Facilities will do quarterly audits on the sprinkler alarm system to ensure all regulations are met. All findings will be brought to the QA committee for review and action.	9/30/2015 ongoing
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on a review of records during the Life Safety Code Inspection, it was determined that Sprinkler Alarm Devices, Such as Flow and Tamper Switches) including Supervisory Signal Devices and Water Gongs test results were not available for review for three (3) of three (3) quarters reviewed. These findings were observed and acknowledged in the presence of the Maintenance Director.	K 056		

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 _____	**08/31/2015**

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 056	Continued From page 4 The findings Include: The Sprinkler Alarm Device Testing Records were requested on August 31, 201 at 1:30 PM. It was determined that quarterly testing records to show the location of devices tested and test results which would reflect that devices passed or failed the test were not available for review as follows: Documentation was not available for Third Quarter July 2014 through September 2014; Fourth Quarter October 2014 through December 2014 and the First Quarter January 2015 through March 2015 in three (3) of three (3) observations. The findings were acknowledged by the Maintenance Director at the time of the review.	K 056	**F062** 1. All affected sprinklers that were affected with dust were cleaned of dust and paint to ensure proper function in the event of an occurrence. All the sprinkler heads and escutcheons plates that had signs of rust were replaced. 2. No resident was affected. Facility wide inspection of sprinkler heads was done and all were cleaned and in proper working order. 3. Maintenance department were educated on routine cleaning of sprinkler heads. A bi-annual cleaning scheduled was initiated. 4. Director of Facilities or designee will do random audits for one month. Then every six months to ensure compliance. All findings will be brought to the QA committee for review.	9/15/2015 9/15/2015 9/15/2015
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that sprinklers in Residents Rooms, Bathrooms and Common Areas were not maintained to ensure proper operation in the event of a fire. Sprinklers were soiled with dust, paint and/or rust accumulation on Shaft, Head Surfaces and/or Escutcheon Rings in the Rehabilitation Treatment	K 062		

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 _____	**08/31/2015**

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 062	Continued From page 5 and Main Kitchen, which may potentially impede the operation of sprinklers in the event of an emergency in 12 of 16 observations. The findings include: 1. The shaft and head surfaces of sprinklers in the Rehabilitation Storage Room were soiled with dust and paint, in one (1) of two (2) observations at 11:20 AM on August 31, 2015. 2. Sprinkler head surfaces were soiled with dust accumulation in the Rehabilitation Treatment Area in three (3) of three (3) observations at 11:30 AM on August 31, 2015. 3. Sprinkler heads were soiled with excessive dust and rust in Food Preparation, Dishwashing and Pot Washing Areas, in the main Kitchen, in eight (8) of 11 sprinkler observations at 12:05 PM on August 31, 2015.	K 062		