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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	095028		**06/24/2016**

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

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K 000	INITIAL COMMENTS	K 000		
	The following findings were identified during the Life Safety Code Inspection conducted June 24, 2016.		**K018** 1. Double doors outside rehabilitation services adjacent (a) to the Nurses Station and double doors to the main dining room were repaired on 7/13/16. They are now closing and latching properly. (b) Single doors on room 170, 184, 191, the visitor's bathroom, oxygen room and soiled linen room were repaired on 7/13/16. They are now closing and latching properly. 2. All double and single doors were inspected on 7/13/16 by the Director of Maintenance and no deficiencies were found with respect to doors not closing and latching properly. 3. The preventative maintenance program has been updated to include daily monitoring of all doors to ensure they close and latch properly. Nursing Staff were inserviced on preventative maintenance log by the Administrator to record all deficiencies relative to doors not closing and latching properly. 4. The director of maintenance will conduct weekly audits for 4 weeks and then monthly to ensure that all doors close and latch properly. Findings will be reported in the Quality Assurance Process Improvement (QAPI) monthly meetings for review and actions.	07/29/16
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 shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that double and single swinging doors failed to latch into frames and doors lacked striker plates to latch into frames; these doors would not prevent the passage of smoke or contain a fire in the event of an emergency in eight (8) of 14 observations. These findings were observed in the presence of the Maintenance Director. The findings include:	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 7/15/16

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 018	Continued From page 1 Double and single doors on the lower level health unit failed to close and latch into frames when tested as follows: A. Double doors located outside of Rehabilitation Services, adjacent to the Nurse ' s Station and double doors to the Main Dining Room failed to close and latch when tested in two (2) of two (2) observations between 10:07 AM and 11:00 AM on June 24, 2016. B. On the first floor health unit, single doors failed to close and latch into frames when tested and were observed without latching plates in the following areas: Rooms 170, 184, 191, the visitor ' s bathroom, oxygen storage room and the soiled linen room in (six) 6 of 14 observations between 9:25 AM and 2:00 PM on June 24, 2016.	K 018	**K025** 1. The 2-3 inches opening and the 1-2 inches opening over the maintenance door to the rehabilitation department were repaired using dry wall on 7/13/16. The 8x10 inch opening in the first floor boiler room was sealed and repaired on 7/13/16. 2. The Director of Facilities conducted a thorough inspection of the facility relative to penetrations and openings and no deficiencies were found. 3. A maintenance staff was inserviced on 7/8/16 on conducting daily inspections to ensure that there are no penetration and opening violations. The preventative maintenance program was updated to reflect data collection on violations of penetrations and openings. 4. The director of facilities will conduct weekly rounds for 4 weeks and then monthly to ensure compliance. Findings will be reported in the Quality Assurance Process Improvement (QAPI) monthly meetings for review and actions.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that penetrations were observed in smoke barrier walls, which would not prevent the passage of smoke in the event of a fire in four (4) of four (4) observations. These findings were observed in the presence of the Maintenance Director.	K 025		07/29/16

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K 025	Continued From page 2 The findings include: 1. A 2-3-inch opening was observed around a 3-inch copper pipe; an 8-inch opening was observed around a ½ inch copper pipe; and a 1-2-inch opening was observed around BX Cable over the main entrance door to the Rehabilitation Department in three (3) of three (3) observations at 9:25 AM on June 24, 2016. 2. A 8 X 10-inch opening was observed around a large copper pipe in the First Floor Boiler Room in (1) of one (1) observation at 11:50 AM on June 24, 2016.	K 025		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on a review of documents during the Life Safety Inspection, it was determined that supporting documents were not available to determine if Water Flow switches such as tamper, flow and supervisory valves were tested on a quarterly basis as required. The findings include:	K 056	**K056** 1. Water flow switch documentation for fourth quarter of 2015 and first quarter of 2016 cannot be retroactively corrected. The next quarterly water flow switch test and documentation will conducted by a contractor on 7/13/16. 2. All water flow switch test and documentation were in compliance on 7/13/16. 3. The maintenance director has instructed the contractor of the required quarterly test and documentation instead of annually. The current contract with the contractor will be updated. 4. The director of maintenance will ensure audits of proper, timely test and documentation for water flow switches. Findings will be reported in the Quality Assurance Process Improvement (QAPI) monthly meetings for review and actions.	07/29/16

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K 056	Continued From page 3 Through a review of facility documentation, it was determined that there was no documentation to support that alarm tests for Water Flow switches such as tamper, flow and supervisory valves were tested on a quarterly basis as evidenced by the lack of documentation for the Fourth Quarter (October, November and December 2015); and First Quarter (January, February and March 2016) in two (2) of three (3) quarters reviewed on June 24, 2016 at 3:30 PM.	K 056	**K062** 1. Sprinklers located in the physical therapy treatment area were cleaned on 7/13/16. Sprinklers located in the hydrocollator room was cleaned on 7/13/16. Sprinklers located in rehabilitation lounge was cleaned on 7/13/16. Sprinklers in the first floor show room was cleaned on 7/13/16.	
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 on June 24, 2016 at approximately 10:15 AM, it was determined that sprinklers were not maintained to ensure proper operation in the event of an emergency as evidenced by the observation of sprinkler heads and/or escutcheon rings soiled with dust or paint in 10 of 15 observations. These findings were observed in the presence of the Maintenance Director. The findings include: 1. Sprinklers were not maintained to ensure proper operation in the event of an emergency as evidenced by head and shaft surfaces that were soiled with dust accumulation in the following areas:	K 062	Sprinkler heads, shaft surfaces, and escutcheon rings in rehabilitation bathroom, fireplace lounge, room 074, soiled linen room, room 187, room 185, first floor soiled linen room will be replaced on 7/28/16. The damaged sprinkler head surfaces in the walk-in refrigerator was replaced on 7/13/16 by a contractor. 2. All sprinklers were inspected on 7/13/16 relative to them being dusty, damaged and painted and no deficiencies were found. 3. A maintenance staff was inserviced by the Administrator on 7/8/16 on conducting daily sprinkler inspections to ensure compliance. 4. The director of maintenance will conduct weekly audits of sprinklers for 4 weeks and then monthly to ensure compliance. Findings will be reported in the Quality Assurance Process Improvement (QAPI) monthly meetings for review and actions.	07/29/16

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K 062	Continued From page 4 Three (3) of three (3) sprinklers in the Physical Therapy treatment area were soiled with dust in as observed at 9:45 AM on June 24, 2016 One (1) of one (1) sprinkler in the Hydrocollator Room was soiled with dust as observed at 9:50 AM on June 24, 2016 One (1) of three (3) sprinklers located in the Rehabilitation Lounge was observed with dust at 9:55 AM on June 24, 2016 One (1) of three (3) sprinklers in the First Floor Shower Room was observed soiled with dust at 10:05 AM on June 24, 2016. 2. Sprinkler heads, shaft surfaces and escutcheon rings were observed with paint on the surfaces in the following areas: Rehabilitation Bathroom in one (1) of one (1) observation Fireplace Lounge in three (3) of five (5) observations Room 74 in one (1) one (1) observation at 9:55 AM on June 24 2014 Soiled Linen Room in one (1) of one (1) observation at 10:00 AM on June 24, 2016 Room 187 in one (1) of two (2) observations at 10:03 AM on June 24, 2016 Room 185 on one (1) of two (2) observations at 10:05 AM on June 24, 2016 First Floor Soiled Linen Room in one (1) of two	K 062		

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K 062	Continued From page 5 (2) observations 11:25 AM on June 24, 2016 A sprinkler head surface in the Walk in refrigerator was damaged, in one (1) of one (1) observation at 11:30 AM on June 24, 2016. The observations were made in the presence of the Maintenance Director who acknowledged the findings.	K 062		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on a review of facility documents during the Life Safety Code Inspection, it was determined that documentation was not available to support exercising of the emergency generator for at least 30 minutes under load each month. This finding was observed in the presence of the Maintenance Director. The findings include: Through a review of documents and interview, it was determined that odometer readings were not recorded on generator testing log sheets. The start and stop odometer times were not recorded to substantiate the operation of the generator for at least 30 minutes under load each month as required. Hourly start and end times were recorded on log sheets which failed to substantiate the actual time of exercises between January 5, 2016 and June 16, 2016 in six (6) of	K 144	**K144** 1. The generator load test document cannot be retroactively corrected. The emergency generator was calibrated on 7/7/16, tested on load for 30 minutes, and properly documented weekly. 2. The emergency generator has received a weekly run test and inspection and no deficiency was found. 3. A maintenance staff was inserviced by the Administrator on 7/8/16 on the importance of weekly test of the emergency generator as required by NFPA. 4. The director of facilities will audit and report an emergency generator violation to the monthly QAPI for review and action.	07/29/16

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K 144	Continued From page 6 six (6) observations at 3:00 PM on June 24, 2016.	K 144		