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 _____	**09/08/2014**

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 annual Life Safety Survey was conducted at your facility on September 8, 2014. The findings were based on observation, record review and staff interviews.	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 and staff interviews during the Life Safety Code Survey conducted on September 8, 2014, it was determined that resident room doors and a common area door failed to close and latch into frames when tested in three (3) of 15 observations on the Lower Level and in six (6) of 16 observations on the	K 018	**K018** 1. Doors to resident rooms #072,082,170 191 & 196, and to common areas, dining room, day room and soiled linen room were all repaired and can close and latch into frames without assistance. 9/18/2014 2. All other doors for resident rooms and other common areas were checked and all can close and latch into frame without assistance. 9/19/2014 3. Maintenance department staff was inserviced by Director of Facilities on fire regulations with the importance of all doors being able to self close and latch. 9/22/2014 4. The Director of Facilities or designee will do weekly audits x 4, then monthly audits to ensure that all doors can close and latch without assistance. Findings will be forwarded to the QA committee for review and action.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ann R. Schiff	Executive Director	10/10/14

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 _____	**09/08/2014**

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 First Level. The findings include: Lower Level On September 8, 2014 between 2:20 PM and 3:05 PM, it was determined that three (3) of 15 entrance doors observed on the Lower Level failed to close and latch into frames when tested. The doors included resident rooms #072 and 082 and the stairwell exit door #6. First Floor On September 9, 2014 between 3:05 PM and 3:55 PM, it was determined that entrance doors to resident rooms, #170, 191, 196, and doors to common areas, the dining room, day rooms, and the soiled linen room, failed to latch into frames without assistance when tested in six (6) of 16 observations. These findings were observed in the presence of the Maintenance Staff.	K 018		
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.	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 _____	**09/08/2014**

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 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

This STANDARD is not met as evidenced by:

Based on observations during the Life Safety Code Survey conducted on September 8, 2014, 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 nine (9) of nine (9) observations.

The findings include:

Penetrations were observed in smoke barrier walls around water pipes, communication wires, and around ceiling tiles which would not prohibit the passage of smoke in the event of a fire.

Lower Level

1. On September 8, 2014 at approximately 2:22 PM, a 1-2 inch penetration was observed in wall surfaces around ductwork in the Electric Closet in one (1) of one (1) observed.

2. On September 8, 2014 at approximately 2:25 PM, the escutcheon rings around two separate sprinkler heads failed to fit properly creating a 1-3 inch opening in ceiling tiles in the Lower Level Biohazard Room in two (2) of two (2) observations.

3. On September 8, 2014 at approximately 2:35 PM, the escutcheon ring and smoke detector failed to fit properly around ceiling tiles leaving a 2-3 inch opening in the ceiling in two

K025

1. All observed penetrations were sealed with gypsum mud. The escutcheon rings around identified sprinkler heads were changed and are fitting properly. The openings around the water pipes and plate covers were sealed. — 9/18/2014

2. Maintenance staff conducted an audit to ensure that there were no penetrations in smoke barrier walls. No other penetrations were observed. All escutcheon rings are fitting properly and no other openings were found around water pipes or plate covers. — 9/19/2014

3. Maintenance department staff was inserviced by Director of Facilities and Staff Educator on fire regulations and life safety codes with importance of maintaining proper smoke barrier walls. — 9/22/2014

4. The Director of Facilities or designee will perform random audits on different areas of facility weekly x 4 and after any task has been completed to ensure proper smoke barrier. Findings will be reported to QA committee for review and action.

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 _____	**09/08/2014**

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 (2) of two (2) observations. First Floor 1. On September 8, 2014 at approximately 3:15 PM, the escutcheon ring around the sprinkler head failed to fit properly; and a 2-3 inch opening was observed in the ceiling tile in the Oxygen Room in one (1) of one (1) observation. 2. On September 8, 2014 at approximately 3:15 PM, the escutcheon ring failed to fit securely around the sprinkler heads and ceiling tiles in the Staff Bathroom creating a 2-3 inch opening in ceiling tile surfaces in one (1) of one (1) observation. 3. On September 8, 2014 at approximately 4:10 PM, a 12 X 20 inch opening was observed around various sizes of water pipes passing through a smoke barrier wall near the entrance to the Rehabilitation Department; and a 1-2 inch opening was observed around a plate cover inside of the Rehabilitation Department in two (2) of two (2) observations. These findings were observed in the presence of the Maintenance Staff.	K 025		
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	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 _____	**09/08/2014**

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 4 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Survey conducted on September 8, 2014, it was determined that facility staff failed to ensure that aspects of the sprinkler system were maintained in reliable operating condition in four (4) of four (4) observations. The findings include: Facility staff failed to ensure that aspects of the sprinkler system were maintained in reliable operating condition in four (4) of four (4) observations. Lower Level On September 8, 2014 at 2:25 PM, the escutcheon rings around two (2) separate sprinkler heads failed to fit properly creating a 1-3 inch opening in ceiling tiles in the Lower Level Biohazard Room in two (2) of two (2) observations. First Floor 1. On September 8, 2014 at 3:20 PM, the escutcheon ring around the sprinkler head failed to fit properly and a 2-3 inch opening was observed in the ceiling tile in the oxygen room in one (1) of one (1) observation. 2.On September 8, 2014 at 3:20 PM, the escutcheon ring failed to fit securely around the sprinkler heads and ceiling tiles in the staff bathroom creating a 2-3 inch opening in ceiling tile surfaces in one (1) of one (1) observation.	K 062	**K062** 1. All identified ill-fitting escutcheon rings for sprinkler heads were replaced and are fitting properly. 2. All other sprinkler heads were checked by maintenance department and the escutcheon rings are fitting properly. 3. Maintenance department staff was re-educated on the requirement of the automatic sprinkler system to ensure that they are maintained in reliable operating condition. 4. The Director of Facilities will ensure that the sprinkler system is continuously maintained by randomly auditing different sprinkler heads weekly x 4, then quarterly. Findings will be reported to the QA committee for review and action.	9/18/2014 9/19/2014 9/22/2014

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 _____	**09/08/2014**

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 These findings were observed in the presence of the Maintenance Staff.	K 062		