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

PRINTED: 09/30/2014 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE	S MEDICAID SERVICES			<u> MB NO. 0</u>	938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		095028	B. WING		09/08	3/2014
	ROVIDER OR SUPPLIER DE AT ROCK CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015	05/05	72014
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFIGIENCY)	BE C	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 000	0		
K 018	your facility on Sept were based on obse interviews.	rety Survey was conducted at ember 8, 2014. The findings ervation, record review and staff	K 018	_s K018		
SS=D	Doors protecting correquired enclosures hazardous areas are those constructed or wood, or capable of minutes. Doors in s required to resist the no impediment to the are provided with a door closed. Dutch permitted. 19.3.6.	ridor openings in other than of vertical openings, exits, or e substantial doors, such as f 1% inch solid-bonded core resisting fire for at least 20 prinklered buildings are only e passage of smoke. There is e closing of the doors. Doors means suitable for keeping the doors meeting 19.3.6.3.6 are 3	KUI	1. Doors to resident rooms #072,08 191 & 196, and to common areas, dinited ay room and soiled linen room were a repaired and can close and latch into frewithout assistance. 2. All other doors for resident rooms are common areas were checked and all can and latch into frame without assistance. 3. Maintenance department staff was in by Director of Facilities on fire regulat with the importance of all doors being self close and latch.	ng room, all rames nd other an close e. nserviced 9 tions	0/18/2014 0/19/2014 0/22/2014
				4. The Director of Facilities or designed weekly audits x 4, then monthly audits and the ensure that all doors can close and late out assistance. Findings will be forwar the QA committee for review and action	dits to h with- ded to	
	This STANDARD is	not met as evidenced by:				
	the Life Safety Code September 8, 2014, room doors and a co and latch into frame	ons and staff interviews during Survey conducted on it was determined that resident ommon area door failed to close is when tested in three (3) of 15 Lower Level and in six (6) of the				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Duector

(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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		095028	B. WING			09/08/2014
NAME OF PROVIDER OR SUPPLIER			•	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	00.00.2014
INGLES	DE AT ROCK CREEK				MILITARY ROAD NW SHINGTON, DC 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
K 018	Continued From pag	ge 1	K	018		
	First Level.					
	The findings include	E				
	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 and the stairwell exi	resident rooms #072 and 082 t door #6.				
	First Floor					
	PM, it was determin- resident rooms, #17 common areas, the the soiled linen room	old between 3:05 PM and 3:55 ed that entrance doors to 0, 191, 196, and doors to dining room, day rooms, and n, failed to latch into frames when tested in six (6) of 16				
	These findings were the Maintenance Sta	observed in the presence of aff.				
K 025	NFPA 101 LIFE SAF	FETY CODE STANDARD	Κ	25		
SS=D	one half hour fire res with 8.3. Smoke bar	constructed to provide at least a sistance rating in accordance rriers may terminate at an vs 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DE: / 1111	E.T. O. TIETETTI	AND HOMAN OF CALCALO		<u> </u>	FORM APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED			
	<u> </u>	095028	B. WING		09/08/2014			
NAME OF P	ROVIDER OR SUPPLIER		- T	STREET ADDRESS, CITY, STATE, ZIP CODE	00,00,20.			
INGI ESI[DE AT ROCK CREEK		Ī	3050 MILITARY ROAD NW				
INGLES.	JE AT ROOK SILLIN			WASHINGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
—— К 025	Continued From pag	ne 2	K 02:					
	19.3.7.3, 19.3.7.5, 1	=	13 v=	J				
		s not met as evidenced by:						
	Based on observations during the Life Safety C 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 (nine (9) observations.			K025 1. All observed penetrations were seale with gypsum mud. The escutcheon ring around identified sprinkler heads were changed and are fitting properly. The openings around the water pipes and pl	gs 9/18/2014			
	The findings include	ı;		covers were sealed.	iuco			
	around water pipes,	observed in smoke barrier walls communication wires, and which would not prohibit the n the event of a fire.		2. Maintenance staff conducted an audito ensure that there were no penetration in smoke barrier walls. No other penetrations were observed. All	= -			
	Lower Level			escutcheon rings are fitting properly an no other openings were found around	ıd			
	a 1-2 inch penetration	2014 at approximately 2:22 PM, on was observed in wall ctwork in the Electric Closet in		water pipes or plate covers.				
	one (1) of one (1) ob	bserved.		3. Maintenance department staff was inserviced by Director of Facilities and				
	PM, the escutcheon sprinkler heads faile inch opening in ceilir	3, 2014 at approximately 2:25 a rings around two separate and to fit properly creating a 1-3 and tiles in the Lower Level two (2) of two (2) observations.		Staff Educator on fire regulations and I safety codes with importance of maintaining proper smoke barrier walls	s.			
				4. The Director of Facilities or designed				
		8, 2014 at approximately 2:35		will perform random audits on differen				
		ring and smoke detector failed deciling tiles leaving a 2-3 inch		areas of facility weekly x 4 and after an	•			
	to fit properly around ceiling tiles leaving a 2-3 inch opening in the ceiling in two			task has been completed to ensure proper smoke barrier. Findings will be reported				

to QA committee for review and action.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		095028	B. WING			09/08/2014
	ROVIDER OR SUPPLIER DE AT ROCK CREEK			305	REET ADDRESS, CITY, STATE, ZIP CODE 50 MILITARY ROAD NW ASHINGTON, DC 20015	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 025	(2) of two (2) observed. First Floor 1. On September 8, the escutcheon ring to fit properly; and a observed in the ceilione (1) of one (1) observed in the ceilione (1) of one (1) observed in the ceilione (1) of one (1) observed in the escutcheon ring sprinkler heads and Bathroom creating a surfaces in one (1) of other controls. 3. On September 8 PM, a 12 X 20 inch covarious sizes of water smoke barrier wall in Rehabilitation Depart was observed aroun Rehabilitation Depart observations.	vations. 2014 at approximately 3:15 PM, around the sprinkler head failed a 2-3 inch opening was ing tile in the Oxygen Room in bservation. 2014 at approximately 3:15 PM, failed to fit securely around the ceiling tiles in the Staff a 2-3 inch opening in ceiling tile of one (1) observation. 3, 2014 at approximately 4:10 opening was observed around er pipes passing through a near the entrance to the rtment; and a 1-2 inch opening and a plate cover inside of the rtment in two (2) of two (2)	K (025		
K 062 SS=E	Required automatic continuously maintai condition and are ins	FETY CODE STANDARD sprinkler systems are ined in reliable operating spected and tested periodically. A 13, NFPA 25, 9.7.5	K	062		

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 095028 B. WING 09/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW INGLESIDE AT ROCK CREEK WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 062 Continued From page 4 K 062 This STANDARD is not met as evidenced by: K062 Based on observations during the Life Safety Code Survey conducted on September 8, 2014, it was 1. All identified ill-fitting escutcheon determined that facility staff failed to ensure that 9/18/2014 aspects of the sprinkler system were maintained in rings for sprinkler heads were replaced reliable operating condition in four (4) of four (4) and are fitting properly. observations. 2. All other sprinkler heads were checked 9/19/2014 The findings include: by maintenance department and the escutcheon rings are fitting properly. Facility staff failed to ensure that aspects of the sprinkler system were maintained in reliable operating condition in four (4) of four (4) 3. Maintenance department staff was reobservations. educated on the requirement of the 9/22/2014 automatic sprinkler system to ensure that Lower Level they are maintained in reliable operating condition. On September 8, 2014 at 2:25 PM, the escutcheon rings around two (2) separate sprinkler heads failed 4. The Director of Facilities will ensure to fit properly creating a 1-3 inch opening in ceiling tiles in the Lower Level Biohazard Room in two (2) that the sprinkler system is continuously of two (2) observations. maintained by randomly auditing different sprinkler heads weekly x 4, then First Floor quarterly. Findings will be reported to the QA committee for review and action. 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.

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		095028	B. WING				09/08/2014
NAME OF PROVIDER OR SUPPLIER INGLESIDE AT ROCK CREEK				3050 MILITAR	ESS, CITY, STATE, ZIP COD RY ROAD NW ON, DC 20015	DΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	χ (E/	PROVIDER'S PLAN OF COI ACH CORRECTIVE ACTION ISS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
K 062	Continued From pag These findings were the Maintenance Sta	observed in the presence of	K	062			
							: