Sent via email: 10/26/2022

Ms. Ranada Cooper
Associate Director
Office of Health Facilities
Health Regulation and Licensing Administration
899 North Capitol St. N.E. 2nd Floor

Dear Ms. Cooper,

A Recertification, Life Safety Code, Emergency Preparedness survey was conducted by the Survey Team from the Department of Health (DOH) - Health Regulation and Licensing Administration at Inspire Rehabilitation and Health Center on July 26th, 2022 through August 5th, 2022.

Please accept this letter and Plan of Correction as part of our compliance. If you have any questions or need additional information, please free to contact me at my office number on 202-785-2577 ext. 6203 or on my cellular number which is 301-326-0039.

Sincerely,

Andrea Brown
Licensed Nursing Home Administrator
Inspire Rehabilitation and Health Center

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING **01** B. WING ______	**08/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	**2131 O STREET NW** **WASHINGTON, DC 20037**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted August 9, 2022, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 494.62. The survey found that the facility followed Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. The census was 169.	E 000	**Inspire Rehabilitation and Health Center Disclaimer:** The facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Departments' directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or admission of any wrong doing.	10/21/22
K 000	INITIAL COMMENTS A Life safety Code survey was conducted at your facility July 26, 2022 and August 9, 2022. The following deficiencies are based on observations, and interview.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to maintain emergency lightning equipment in good working condition as evidenced by two (2) of two (2) emergency egress exit signs that did not illuminate. The findings include:	K 293	**K293** **CORRECTIVE ACTION FOR AFFECT AREA:** Exit signage. Two exit signs mounted on each side of the double fire doors on the 5th floor were repaired. Rounds were conducted by the maintenance team and 3 other lights were identified and repaired on 09/28/2022. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** No resident were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE:** Facility Administrator/designee to educate Maintenance Director on the importance of maintaining emergency lighting equipment are well illuminated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea D. Brown
TITLE: Administrator
(X6) DATE: 10/26/2022

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 293	Continued From page 1 During a life safety code walkthrough of the facility on August 9, 2022, at approximately 10:00 AM, two (2) of two (2) exit signs, mounted on each side of a double fire door located on the fifth floor (North Wing), failed to provide continuous illumination. This deficient practice could delay staff and residents from quickly identifying proper egress in case of an emergency. Employee #14 confirmed the findings during a face-to-face interview on August 9, 2022, at approximately 3:30 PM.	K 293	Maintenance Director/designee will in-service maintenance staff on daily rounds to ensure non working lights are identified, reported and repaired timely. **MONITORING CORRECTIVE ACTION:** The maintenance director to complete house wide audits to ensure compliance of safety standards weekly x 4 and monthly x 3 Finding will be reported at monthly safety and QAPI meeting monthly x 3 months.	