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 _____	**11/16/2023**

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 November 16, 2023, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 483.73. The survey found that the facility was in compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility's bed capacity is 180, the census was 175. INITIAL	E 000	Inspire Rehab and Health LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	
K 000	COMMENTS A life safety code survey was conducted at your facility on November 15, 2023. The following deficiencies are based on observation, interview, and record review.	K 000	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** An audit was done by the Maintenance Director for all fire sprinklers to ensure they are properly mounted to the ceiling tile. The audit was completed on 12/6/2023.	12/8/2023
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to maintain fire sprinklers mounted to	K 372	Negative findings were corrected upon discovery. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. An audit was done by the Maintenance Director for all fire sprinklers starting 11/15/23. The audit was completed on 12/6/23 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCCURRENCE:** Nurse Educator/Designee will in-service all staff and leadership on the Policy and procedures for reporting fire sprinkler tiles that don't look to be in safe working order and/or condition.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Cheli	Administrator	12/8/2023

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 372	Continued From page 1 ceiling tiles in safe working condition, as evidenced by penetrations that were observed on the surface of ceiling tiles, around sprinkler heads, on five (5) of five (5) resident care floors. Penetrations in ceiling surfaces could prevent or delay fire sprinklers from discharging in the event of a fire. These findings were observed in the presence of the facility administrator and/or the director of environmental services. The findings include: Penetrations were observed in ceiling surfaces around sprinkler heads and escutcheon rings located in the hallway of all resident care floors as followed: Fifth floor: Ceiling tiles located in front of resident room #501, #502/504, #505, #507, #512, #515, #519, #521, the nursing station and the resident care coordinator office. Fourth floor: Ceiling tiles located in front of resident room #406, the nursing station, and past the double door on the north wing. Third floor: Ceiling tiles located in front of resident room #303, #315, and at the entrance of the east wing. Second floor: Ceiling tiles located in front of resident room #201, and the nursing station. First floor: Ceiling tiles located in front of resident room #103.	K 372	The education was completed on 12/6/23. Education will be given to all maintenance personnel to ensure the sprinklers are properly mounted on the ceiling tiles. This was completed on 12/6/23. Negative findings, if any, will be corrected upon discovery. **MONITORING CORRECTIVE ACTION:** An audit will be done by the Administrator/designee to ensure the facility implements its policy on fire sprinkler tiles. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/6/2023.	

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K 372	Continued From page 2 Employee #1 acknowledged the findings during a face-to-face interview on November 15, 2023, at approximately 11:00 AM.	K 372		