STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	**1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005**

(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 following finding was observed during a Life Safety Code survey conducted September 21, 2016.	K 000		
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 above ceiling tiles, which would not prevent the passage of smoke in the event of a fire in three (3) of 11 observations. The findings include: 1. Penetrations approximately 1-2 inches were observed in smoke barrier walls above ceiling tiles near Rooms 212, 216 and between Rooms 217 and 218 in in three (3) of 11 observations at 1:30 PM on September 21, 2016.	K 025	1. The three penetrations were sealed immediately. 2.Plant Operations Director or designee will conduct a round to identify any other penetration. 3. Plant Operations Director will re-in-service maintenance staff on their responsibility to check behind vendors to ensure penetrations are sealed. 4. Plant Operations Director will document findings and report to the Quality Assurance Committee monthly for review, evaluation, and recommendations. 11/7/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Adler	Executive Director / N/H/A	11/2/16

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.