THE RESIDENCES AT

# THOMAS CIRCLE

In-town Senior Living

October 2, 2015

Ms. Sharon Williams Lewis
Program Manager
Department of Health
899 N. Capitol Street, N.E.
Suite 200
Washington, DC 20002
(202) 442-4737

**Re: Plan of Correction LSC**

Dear Ms. Lewis:

Attached you will find the Plan of Correction for the Life Safety Survey conducted at The Residences at Thomas Circle on August 27, 2015.

Please feel free to contact Angie Layfield, NHA, Executive Director, with any questions regarding the attached Plans of Correction at your convenience. I can be reached at (202) 626-5789 or layfieldangie@thomascirlce.com.

Regards,

Angela C. Layfield, NHA
Executive Director

Attachments

| 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**<br>B. WING _____ | 08/27/2015 |

| 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<br><br>The following findings are based on observations, and staff interview during the Life Safety Code survey conducted on August 27, 2015.<br><br>K 018 NFPA 101 LIFE SAFETY CODE STANDARD<br>SS=D<br><br>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<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br><br>Based on observations during the Life Safety Code Inspection of ten (10) entrance doors to resident rooms, it was determined that three (3) entrance doors failed to close when tested and one (1) entrance door was impeded from closing when the bathroom door was open. These findings were observed and acknowledged in the presence of the Maintenance Director. | K 000 | The Residences at Thomas Circle files this Plan of Correction for the purposes of regulatory compliance. The facility is submitting this document to comply with applicable law and not as an admission or statement of agreement of deficient practices herein.<br><br>K 018 **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Immediate corrective action resulted in adjustment to these doors and removal of the damaged threshold that was preventing the entry door at 209 from closing.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by doors that do not latch and or close properly. Upon discovery, all doors were checked and found to close/latch properly.<br><br>**What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** Plant Operations Supervisor, or designee, will conduct bi-weekly door checks to ensure mechanism is working properly. Any issues identified will be resolved immediately. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| MHA | Executive Director/Administrator | 9/30/15 |

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 018 | Continued From page 1<br><br>The findings include:<br><br>During a tour of the Nursing Unit it was determined that entrance doors to resident rooms failed to close and latch into frames when tested and a bathroom door impeded an entrance door from closing as follows:<br><br>1. Entrance doors to Rooms 209, 212 and 216 were difficult to open and close, which potentially could interfere with residents evacuating their rooms in the event of a fire in three (3) of ten (10) observations between 9:15 AM and 10:00 AM on August 27, 2015. Reference NFPA 19.3.6.3.6<br><br>2. The bathroom door in Room 217 impeded the entrance door from closing which could potentially interfere with the resistance of the passage of smoke in the event of a fire in one (1) of ten (10) observations between 9:15 AM and 10:00 AM on August 27, 2015. Reference NFPA 19.3.6.3.6<br><br>The findings were acknowledged by the Director of Maintenance at the time of the observations. | K 018 | **How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** Door closure/lock inspection will also be completed by the Maintenance Director on a monthly basis and reviewed monthly during QA meetings. Any malfunctioning components will be repaired/replaced immediately. | 10/3/15 |
| | | K 062 | **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Corrective action resulted in cleaning of the ansul piping, removing dried grease droplets that had formed above the range. This was completed the same evening, after the kitchen was closed. | |
| K 062 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by: | | **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents had the potential to be affected by this issue. All pipes were cleaned to ensure no build-up of dust was present. On 9/15/15, Simplex Grinnell conducted their quarterly inspection and found all sprinkler pend- | |

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| K 062 | Continued From page 2<br><br>Based on observations during the Life Safety Code Inspection, it was determined that the Ansul Sprinkler System installed under Cooking Hoods and Standard Pendant Sprinklers in the Main Kitchen, Dishwasher Room and Dining Room were not maintained to ensure proper operation in the event of a fire in 16 of 18 observations. These findings were observed in the presence of the Maintenance Director.<br><br>The findings include:<br><br>During a tour of the Main Kitchen on August 27, 2015 between 10:05 AM and 10:15, it was determined that the Ansul Automatic Sprinkler System was not continuously maintained in reliable operating condition in the event of a fire as evidenced by the following:<br><br>1. Dust accumulation was observed on nine (9) of nine (9) Standard Pendant Sprinklers in Food Preparation Areas under cooking hoods<br><br>2. Accumulated dust and rust was observed on the shaft and head surfaces of three (3) of three (3) Standard Pendant Sprinklers in the Dishwasher Area<br><br>3. Accumulated dust and rust was observed on (4) of four (4) Standard Sprinklers in the Walk in Refrigerator<br><br>The findings were confirmed with the Maintenance Director at the time of the observations. Reference NFPA 18.7.6, 19.7.6, 4.6.12 and NFPA 25, 9.7.5. | K 062 | ants and heads to be in good working order.<br><br>**What measures will be put into place or what systematic changes will be made to insure that the deficient practice does not recur?** All sprinkler heads, pendants and piping will be inspected on a monthly basis by the Plant Operations Supervisor, or designee, to ensure no build-up of dust and rust. If any are found to be rusted or dusty, they will be cleaned or replaced as is appropriate.<br><br>**How will the corrective action be monitored to insure the deficient practice will not recur, and what QA practice will be put into place?** The Plant Operations Director, will conduct a monthly audit of sprinkler heads, pendants and piping to ensure that they are in good working order. Findings will be presented at QA. | 10/3/15 |