STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	**2425 25TH STREET SE** **WASHINGTON, DC 20020**

(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 A life safety code survey was conducted at your facility February 18, 2020. The following deficiencies were based on observation, interview and record review.	K 000	Transitional Care Center- Capitol city is filing this Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not an admission that any of the deficiencies identified are correct. This Plan of Corrections is to serve as the facility's credible allegation of Compliance with all requirement of the Medicare/Medicaid Program.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, fire sprinkler heads were not maintained to ensure proper operation in the event of an emergency as evidenced by sprinklers with rust or foreign substance on the shaft and/or head surfaces in 10 of 12 observations. Findings included ...	K 353	1. The 3 rusted escutcheon rings in the kitchen were cleaned thoroughly; the dust particles from 10 sprinkler heads in the laundry room were cleaned; the missing escutcheon ring in room # 251 were replaced. 2. The facility recognizes that all sprinkler equipment may be impacted by this finding. 3. Staff was educated to report any noted issues with sprinkler heads and escutcheons. 4. Facility Maintenance/Housekeeping staff will perform a visual audit of sprinklers as part of a weekly maintenance inspection during annual survey then monthly with reporting finds to the QAPI committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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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K 353	Continued From page 1 1. During a Life Safety Code inspection in the main kitchen on February 9, 2020 at approximately 7:42 AM, fire sprinkler heads and escutcheon rings were rusted throughout in three (3) of 25 observations. 2. During a Life Safety Code inspection in the laundry room on February 18, 2020, at approximately 11:07 AM, fire sprinkler heads were covered with dust particles in ten (10) of ten (10) observations. 3. During an environmental walkthrough of the facility on February 10, 2020, at approximately 11:00 AM, one (1) of two (2) escutcheon ring in resident room #332 was missing and one (1) of one (1) escutcheon ring in the bathroom of resident room #251 was rusted throughout. These findings were acknowledged by Employee #14 and Employee #15 on February 18, 2020, at approximately 1:00 PM.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller	K 363	1. Maintenance repaired the positive latch on entrance doors for rooms #103, #114, #119, #122, #226 and #342 on 3/20/2020. The hinges for entrance door to room #130 have been repaired on 3/20/2020. 2. The double doors on 2 North at the entrance of the “G” wing on 2 North and 3 North, and the double door to the multi-purpose room on 2 South were repaired to maintain complete closure. For the multi-purpose room on 2 South, a quote was received on January 31, 2020 and contract with Precision was signed on March 5, 2020.	

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	095022	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2020**

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K 363	Continued From page 2 latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, entrance doors to resident's room and double doors to common areas were inadequately maintained to ensure positive latching in case of an emergency. This deficient practice could affect the residents assigned to the room as well as staff and visitors, if smoke were to enter these areas in a fire emergency. Findings included ...	K 363	Doors are scheduled for delivery on April 6, 2020 and waiting for installation date. 3. The facility recognizes that all doors may be impacted from this issue. Staff was educated to report any issues with improper door closure to the Maintenance department. 4. An audit of resident rooms and double fire doors will be performed weekly with reporting of findings to the QAPI committee to ascertain compliance.	

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K 363	Continued From page 3 During a Life Safety Code inspection on February 12, 2020, at approximately 9:30 AM, it was observed that entrance doors to six (6) of 180 resident rooms and double doors located in resident common areas did not latch when tested. This did not meet the requirements of LSC sections 19.6.3.10. 1. The entrance door to resident room #103, #114, #119, #122, #226 and #342 failed to latch into frame when tested, six (6) of 180 resident's rooms. 2. The entrance door to resident room #130 was broken at the hinges and failed to latch fully into the door frame as expected, one (1) of 180 resident's rooms. 3. The double door to 2 north unit, the double door to the 'G' wing on 2 north and 3 north and the double door to the multi-purpose room on 2 south failed to close completely when tested, four (4) of 18 double doors tested. These findings were acknowledged by Employee #14 and Employee #15 on February 18, 2020, at approximately 1:00 PM.	K 363		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918	1. A two hour emergency generator load bank test was performed on 3/3/2020 with supportive documentation and findings. 2. The facility recognizes the impact of required testing of emergency power for application in the event of an emergency.	

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OMB NO.0938-0391	**095022**	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2020**

Name of Provider or Supplier	
TRANSITIONS HEALTHCARE CAPITOL CITY	

			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued From page 4 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure that an annual two-hour load bank test was completed for one (1) of one (1) generator, which was not tested monthly under a minimum load of 30%. Findings included ... Documentation to show that an annual two-hour	K 918	3. Maintenance staff was educated to the need to perform regularly scheduled annual 2 hours load bank tests and monthly minimum load (30%) testing. 4. A report will be performed monthly to demonstrate compliance with the required testing with submission to the QAPI committee.	

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K 918	Continued From page 5 load bank test was completed for one (1) of one (1) emergency generator was unavailable. These findings were acknowledged by Employee #14 and Employee #15 on February 18, 2020, at approximately 1:00 PM.	K 918		
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to document weekly inspections for one (1) of one (1) fire pump. Findings included ... Documentation for the weekly inspection of one (1) of one (1) fire pump was not available for review. Employee #14 demonstrated how the weekly fire pump inspection is done but confirmed on February 18, 2020, that the weekly inspection of the fire pump is not documented. These findings were acknowledged by Employee #14 and Employee #15 on February 18, 2020, at approximately 1:00 PM.	K 919	1. The weekly inspection of the noted fire pump was performed on 2/19/2020. 2. The facility recognizes the need to maintain weekly inspection of all fire pumps for fire suppression. 3. Maintenance staff was educated on the need for weekly inspections of fire pumps. 4. An audit of fire pump inspections will be performed weekly to maintain and Director will report result of findings to the QAPI committee to maintain compliance with this requirement,	