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	Transitions 12/14/2018

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 The following findings were identified during the Life Safety Code inspection conducted December 5, 2018, through December 7, 2018.	K 000	Healthcare Capitol City is filing the Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not An admission of any of the deficiencies. This Plan of Correction is to serve as the facility's credible allegation of compliance with all requirements of Medicare/Medicaid programs.	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to update floor evacuation diagrams to reflect changes in the physical structure of the building. Findings included ... During a review of the facility's floor evacuation diagrams with the actual configuration of the building, on December 5, 2018, at approximately 2:00 PM, twelve (12) of 180 resident's rooms were improperly identified as occupancies for four (4) residents and one (1) of one (1) dialysis facility was not included in the basement floor evacuation diagram. 1. The facility's floor evacuation diagrams incorrectly identified resident's rooms #127 and #129, #132 and #134, #227 and #229, #232 and #234, #327 and #329, #332 and #334 as occupancies for four (4)	K 211	1. Facility floor evacuation plans cited during survey for incorrected identified twelve (12)out of one hundred eighty (180) resident rooms and Dialysis facility located in basement area, and facility has contracted vendor to design evacuation floor plans. **2. Residents with the potential to be affected** Facility Director inspected additional areas to identify all areas are in compliance with diagrams to meet means of egress. **3. Systemic changes to be implemented** • Facility has contracted with vendor to design evacuation floor plans to meet requirement for Life Safety Code 101. Plan have been Scheduled for delivery in the first Quarter.	12/19/18 12/19/18 12/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/5/19

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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	095022	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/14/2018

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K 211	Continued From page 1 residents. In actuality, these rooms are divided by a wall and are each occupied by two (2) residents. 2. One (1) of one (1) dialysis facility located in the basement area of the building was not identified in the evacuation diagram for that floor. Employee #3 acknowledged the findings during a face-to-face interview on December 5, 2018, at approximately 2:00 PM.	K 211	**4. To sustain and maintain compliance** • Facility Director will update Delivery and posting of the The evacuation plans to the QAPI committee on 1/28/19. present	2/7/19 Monthly Quarterly
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	K 353	1.Rust or discoloration on sprinkler heads/ Escutcheons in shower rooms and tub rooms, ten (10) of twelve (12) have been cleaned. **2. Residents with the potential to be affected** A walkthrough was done throughout the facility and Sprinklers / Escutcheons were inspected and those with rust and scale were cleaned. **3 Systemic changes to be implemented** • Maintenance staff was in-serviced on the rust on sprinklers. • Maintenance Supervisors will inspect for rust on a monthly basis and forward the results of these inspections to the Director of Facility for his analysis.	12/7/18 12/13/18 12/14/18

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K 353	Continued From page 2 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 ... During a Life Safety Code inspection on December 5, 2018, through December 7, 2018, fire sprinkler heads in shower rooms and tub rooms were observed with rust or discoloration in ten (10) of 12 observations: 1. Two (2) of two (2) fire sprinklers in the shower room on 1 North. 2. Two (2) of two (2) fire sprinklers in the shower room on 2 South. 3. One (1) of two (2) fire sprinklers in the tub room on 2 South. 4. One (1) of two (2) fire sprinklers in the tub room on 3 South. 5. Two (2) of two (2) fire sprinklers in the shower room on 3 North. 6. Two (2) of two (2) fire sprinklers in the tub room on 3 North. During a face-to-face interview on December 6, 2018, at approximately 11:00 AM, Employee #3 confirmed the findings.	K 353	**4. To sustain and maintain for compliance** • The Director of Facility will present these findings with any action plans for improvement to the QAPI Committee which meets monthly, and which is chaired by the Nursing Home Administrator. • The Director of Facility will present the results for three (3) consecutive months for compliance. • QAPI Committee will determine compliance	2/7/19 Monthly and Quarterly
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		

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K 363	Continued From page 3 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 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:	K 363	1.Resident rooms entrance doors for rooms #103, 108, 112, 154, 205, 237, 251, 260, and 313 that did not have positive latch were repaired upon discovery.	12/7/18
			2. **Residents with potential to be affected** Walkthrough was done in facility and residents room doors were tested to ensure a positive latch.	12/20/18
			3. **Systemic changes to be implemented** • Maintenance staff was in-serviced by Director of Facility on the repair of residents room doors. • Maintenance supervisors will test the proper latching of these doors on a monthly basis and forward the results of these tests and replacements to the Director of Facility for his analysis.	12/14/18
			4. **To sustain and maintain for compliance** • The Director of Facility will present these findings with any action plans for improvement to the QAPI Committee which meets monthly and is chaired by the Nursing Home Administrator. • The Director of Facility will present the findings for three (3) consecutive months for compliance, and Quarterly thereafter. • QAPI Committee will determine compliance.	2/7/19 Monthly and Quarterly

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K 363	Continued From page 4 Based on observation and staff interview, entrance doors to resident's room 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. During a Life Safety Code inspection on December 5, 2018, through December 7, 2018, it was observed that entrance doors to nine (9) of 180 resident rooms did not latch when tested. This did not meet the requirements of LSC sections 19.6.3.10. Findings included ... Entrance doors to resident's rooms failed to latch (#103, #108, #112, #154, #205, #237, #251, #260, and #313) in nine (9) of 180 resident's rooms. During a face-to-face interview on December 6, 2018, at approximately 11:00 AM, Employee #3 confirmed the findings.	K 363		