STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/16/2021

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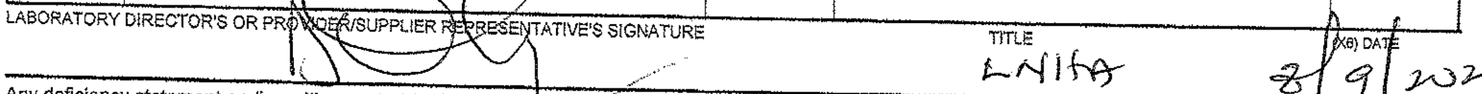
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K353	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life safety Code survey was conducted at your facility June 14, and June 16, 2021. The following deficiencies are based on observation, interview, and record review.	K 000		
K 353 SS=D	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 a bent fire sprinkler head deflector in one (1) of nine (9) resident care units, a bent fire sprinkler head deflector in the Crystal room and a rusty fire sprinkler in the walk-in freezer. The findings include:	K 353	**Stoddard Baptist Global Care makes its best effort 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 of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is pre pared and/or executed solely because it is required by Federal and State Law.** **SPRINKLER SYSTEM SEE NEXT PAGE**	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE LNHA — (X6) DATE 8/9/2021

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 During a Life Safety Code inspection of the facility on June 14, 2021, at approximately 10:30 AM: 1. One (1) of seven (7) fire sprinklers in resident room #106, on unit 1 Blue, was bent at the deflector. 2. One (1) of 28 fire sprinklers located in the Crystal room was bent at the deflector. 3. One (1) of one (1) fire sprinkler located in the walk-in freezer was rusted throughout. This deficient practice could prevent the fire sprinkler from discharging water in the event of a fire emergency. During a face-to-face interview on June 22, 2021, at approximately 2:00 PM, Employee #6 acknowledged the findings.	K 353	**Corridors/ Doors** **1) The fire sprinkler located in RM 106, Crystal room, and walk in freezer were replaced on 6/16/2021. Facility residents did not suffer any negative outcome.** **2) Maintenance Supervisors conducted facility wide inspection of sprinkler heads, and other devices to identify and repair bent fire sprinkler head deflector. No other devices were identified.** **3) Maintenance manager provided education to maintenance staff on the importance of frequent rounding to identify and timely replace or repair devices as needed. The Maintenance team will conduct weekly Inspection on devices including bent fire sprinkler head deflector. Any device identified with buildup corrosion will be repaired or replaced.** **Report of weekly inspection will be reviewed for completion and forwarded to the Quality Assurance Committee monthly. Weekly inspection log will be submitted to the Maintenance manager.**	**JUNE 30, 2021**
K 363 SS=E	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 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	K 363		

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K 363	Continued From page 2 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 observations and staff interview, entrance doors to resident's rooms and fire doors in commons areas were inadequately maintained to ensure proper latching in the event of an emergency. The findings include: During a Life Safety Code inspection of the facility on June 14, and June 16, 2021, at approximately 10:00 AM and a mock fire drill on June 17, 2021, at approximately 2:45 PM, the following were observed:	K 363	**1) The entry doors labeled C33, B53.1, C36, B57 were repaired on 6/17/2021 to ensure proper latching. Facility residents did not suffer any negative outcome.** **2) Maintenance Supervisors conducted facility wide inspection on doors to ensure adequate latching and closure during emergency. No other devices were identified.** **3) Maintenance manager provided education to maintenance staff on the importance of frequent rounding to identify and timely replace or repair doors to ensure adequate latching and closure during emergency. The Maintenance team will conduct weekly Inspection on doors to ensure adequate latching and closure during emergency. Any door identified will be repaired or replaced.** **4) Report of weekly inspection will be reviewed for completion and forwarded to the Quality Assurance Committee monthly. Weekly inspection log will be submitted to the Maintenance manager.**	**JUNE 30, 2021**

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K 363	Continued From page 3 1. Entrance door to resident's rooms #336, #364, did not latch into frame to when tested on two (2) of two (2) observations. 2. One (1) of one (1) fire door, labeled C33, by the laundry room, failed to latch during a fire drill on June 17, 2021. 3. One (1) of one (1) fire door, labeled B53.1, leading to the Rehab Gym, failed to latch during a fire drill on June 17, 2021. 4. One (1) of one (1) fire door, labeled C36, in the hallway of the basement, failed to latch during a fire drill on June 17, 2021. 5. One (1) of one (1) fire door, labeled B57, in the hallway of the basement, failed to latch during a fire drill on June 17, 2021. This deficient practice could affect residents, staff, and visitors, if smoke could spread from a hazardous area through occupied, common areas in the facility. During a face-to-face interview on June 22, 2021, at approximately 2:00 PM, Employee #6 acknowledged the findings.	K 363		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		

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K 918	Continued From page 4 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 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 interview, it was determined that facility staff failed to exercise three (3) of three (3) emergency generators monthly, under load, at a minimum of 30% of their nameplate Kilowatts (KW) rating, nor	K 918	**Electrical Systems** **1) Facility emergency generator was tested by generator service contractor and met required load test. Generator logs have been updated with new testing procedures to show that each load test is in compliance with the 30% minimum requirement.** **2) Generator service contractor reviewed emergency generator manual and NFPA 110 guidelines with facility maintenance team to enhance staff understanding needed on correct operations testing, and log documentation of emergency generator was tested and met the required 30% minimum load test requirement.** **3) Maintenance staff was trained by the generator service contractor on the proper operation, testing and limitations of the equipment. Training was extended to accurate documentation as evidence for the 30% minimum load test. Maintenance manager will review generator weekly testing and inspection logs after each test x4.** **4) Reports of weekly inspection log will be submitted to Quality Assurance Committee monthly. Weekly inspection log will be submitted to the Maintenance manager.**	**JUNE 30, 2021**

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K 918	Continued From page 5 annually with supplemental loads as required by NFPA 110, section 8.4.2 and 8.4.2.3. Which state: 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that contains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and not at less than 30 percent of the EPS standby nameplate KW rating. 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads of not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. The findings include: A review of the facility's emergency generator logs from June 2020, through May 2021, show that three (3) of three (3) emergency generators were exercised monthly, under load. However, the available documentation failed to show that all three (3) emergency generators were tested monthly, as required, under a minimum load of 30% or annually under an applied load bank test. Employee #5 was made aware of these findings	K 918		

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K 918	Continued From page 6 on June 16, 2021, at approximately12:00 PM, and on June 22, 2021, at approximately 2:00 PM.	K 918		