STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HILL NURSING CENTER	**700 CONST. AVE. NE** **WASHINGTON, DC 20002**

(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 are based on observations and record review during the Life Safety Code Survey conducted at your facility on August 11, 2014.	K 000	Response begin on page 2	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that Fire, Smoke Barriers, Resident Rooms and common entrance doors failed to close and latch into frames when tested in nine (9) of 33 observations. The findings were observed in the presence of the Interim Director of Maintenance	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maria Allen	Nursing Home Administrator	9/9/2014

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 and Administrative Staff. The findings include: During the Life Safety Code Inspection on August 11, 2014 at 10:30 AM, it was determined that double swinging fire doors, smoke barrier doors, resident room doors and doors in common areas failed to close or were difficult to close and open when tested in the following areas: Fourth Floor 1. Double Fire Doors at the entrance to 4 West and 4 East failed to fully close when tested in two (2) of two (2) observations between 9:40 AM and 10:20 AM on August 11, 2014. 2. Single entrance doors to rooms 4143 and 4141 failed to close and latch and the entrance door to room 4124 lacked a latch to remain closed when tested in three (3) of 16 observations between 9:40 AM and 10:20 AM on August 11, 2014. Fifth Floor 1. The entrance door to rooms 5153 and 5104 fails to close and latch when tested between 10:30 AM and 10:55 AM on August 11, 2014. Sixth Floor 1. Double Smoke doors near 6144 on Unit 6 West failed to close when tested at 11:00 AM in one (1) of two (2) observations on August 11, 2014.	K 018	1. Double Fire Doors at the entrance of 4 West and 4 East will be fixed. Single entrance doors to room 4143 and 4141 will be fixed. Entrance door to rooms 5153 and 5104 will be fixed. Double smoke doors near 6144 on Unit 6 West will be fixed.. 2. Maintenance Director will conduct a life safety round to identify doors not latching/closing. 3. Maintenance Director or designee , Director of Housekeeping or designee, Administrator or designee, and Resident Care Coordinator or designee will conduct monthly rounds. 4. Maintenance Director will document the findings and present to the Quality Assurance Committee for review, evaluation, and recommendations on an ongoing monthly basis.	**9.12.2014**

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K 018	Continued From page 2 2. The lock on the entrance door to room 6143 was not secured and failed to latch when tested in one (1) of one (1) observation at 11:10 AM on August 11, 2014.	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that wall surfaces above ceiling tiles would not prevent the passage of smoke through smoke barrier walls in the event of an emergency in three (3) of three (3) observations. These findings were observed in the presence of the Maintenance Director and Maintenance Staff. The findings include: Fourth Floor 1. A 4 - 6 inch opening was observed in the ceiling around a around a 3 inch drain pipe over the Ice Machine in the Pantry Room of the	K 025	1. The 4-6 inch opening in the ceiling around a 3 inch drain pipe over the ice machine in the 4th floor pantry room will be sealed. A 5 by 5 inch opening on the wall surfaces above lockers in room 5203 will be sealed. A large opening approximately 5 by 6 inches in wall surfaces of the fifth floor shower room will be sealed.. 2. Director of Maintenance or designee will conduct environmental rounds to identify wall openings. 3. Director of Maintenance or designee, Director of Housekeeping or designee, Administrator or designee, Resident Care Coordinator or designee will conduct Life Safety Rounds/Environmental rounds. 4. Maintenance Director will document the findings and present to the Quality Assurance Committee for review, evaluation, and recommendations on an ongoing monthly basis.	**9.12.2014**

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K 025	Continued From page 3 fourth floor in one (1) of one (1) observation at 9:40 AM on August 11, 2014. Fifth Floor 1. A 5 X 5 inch opening was observed in wall surfaces above lockers in room 5203, Staff Locker Room on the fifth floor in one (1) of one (1) observation at 10:30 AM on August 11, 2014. 2. A large opening approximately 5 X 6 inches was observed in wall surfaces of the fifth floor Shower Room in one (1) of one (1) observation at 10:40 AM on August 11, 2014.	K 025		
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview during the Life Safety Code Inspection, it was determined that Fire Safety test results were not available for review as evidenced by the lack of documentation related to regular maintenance and testing of the Fire Alarm and Sprinkler systems and Emergency Generators in three (3) of three (3) observations. Additionally, Fire Drill Records and the Fire Manual was not available for review in two (2) of two (2) observations. These findings were observed in the presence of the Interim Director of Maintenance and Administrative Staff. The findings include:	K 130		

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K 130	Continued From page 4 1. During the Life Safety Code Inspection, it was determined that testing and maintenance results for Fire Alarm System, was not available to reflect that the Fire Alarm System was installed, tested and maintained in accordance with NFPA 70 [National Fire Protection Association] in one (1) of one (1) observation between 1:30 PM and 3:30 PM on August 11, 2014. 2. There was a lack documented evidence to show that the Automatic Sprinkler System had been maintained in accordance with NFPA 18.7.6, 19.7.6 and 4.6.12, NFPA 13, NFPA 25, 9.7.5. This finding was observed between 2:00 PM and 3:00 PM on August 11, 2014 in one (1) of one (1) observation. 3. There were no records available for review to reflect that the Emergency Generator was exercised and inspected weekly and exercised at least 30 minutes each month in accordance with NFPA 99, 3.4.2.2 and 3.4.2.1.4. This finding was observed between 1:30 PM and 3:30 PM on August 11, 2014 in one (1) of one (1) observation. 4. There was no evidence of records to reflect that Fire Drills were conducted at least once per quarter, per shift and that drills were held at unexpected times in one (1) of one (1) observation between 2:00 PM and 3:30 PM on August 11, 2014. NFPA 18.17.1.2 and 19.7.1.2. 5. There was no Fire Manual to show that a written plan exists for the protection of all patients and staff in the event of an emergency in one (1) of one (1) observation at 1:30 PM on August 11, 2014. NFPA 18.7.1.1 and 19.7.1.1.	K 130	1. Vendor will conduct a test of the Fire Alarm System by 9/12/14. Vendor will conduct an inspection of the Automatic Sprinkler System by 9/12/14. Emergency Generator test records have been found and are attached to this Plan of Corrections. Fire Drill records have been found and are attached to this Plan of Corrections.. 2. Maintenance Director will audit records to ensure facility is compliant with inspections and tests. 3. Maintenance Director will upload documents for Fire Alarm System test, Automatic Sprinkler System inspections, Emergency Generator Test, and Fire Drill records to the intranet to ensure availability for review and inspection. Administrator will audit records monthly to ensure compliance. 4. Administrator will document the findings and present to the Quality Assurance Committee for review, evaluation, and recommendations on an ongoing monthly basis.	**9.12.2014**

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K 130	Continued From page 5 The findings were acknowledged by the Interim Director of Maintenance and Administrative Staff at the times of the observations.	K 130		