STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(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 Based on observations during the annual Life Safety Code survey of your facility, the following findings were observed on June 30, 2008.	K 000	THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.	
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 double fire and entrance door to residents rooms failed to close when tested. These findings were observed in the presence of the Maintenance Director, Employee # 1. The findings include:	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/ADMINISTRATOR	8 JULY 2008

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 Double fire doors and single entrance doors to resident ' s rooms failed to close when tested without assistance which would not prevent the passage of smoke in the event of a fire. 1. The entrance door to the laundry room failed to close and latch into the door frame when tested in one (1) of one (1) observation at 9:40 AM on June 30, 2008. 2. Double doors located at the entrance to the Physical Therapy failed to close and latch when tested in one (1) of (4) observations at (9:45 AM on June 30, 2008. 3. The pantry entrance door failed to close and latch into the door frame when tested in one (1) of one (1) observation at 9:50 AM on June 30, 2008. 4. The entrance door to room 249 failed to close and latch into the door frame tested in one (1) of five (5) observations at 10:15 AM on June 30, 2008.	K 018	**K 018 NFPA Life Safety Code Standard** 1. Corrective Action for Residents Affected by Deficient Practice: No resident(s) was(were) negatively impacted. The entrance door to the laundry room, the double doors at the entrance to the Therapy room, the pantry doors and the entrance door to room 249 were adjusted allow for positive latching. — 7/1/08 2. Method to Identify Other Residents At Risk for Deficient Practice: All doors in the Health Care Center were tested and found to be closing and latching appropriately. — 7/1/08 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Door latch check added to maintenance rounds. Nursing also advised of latching requirement and reminded to notify Maintenance if adjustments / repair to any doors are necessary. — 7/1/08 • On a monthly basis, doors in the Health Care Center will be randomly checked by Director of Maintenance Services to ensure deficient practice does not recur. 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.** — 7/24/08	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection it was determined that the smoke detector in the dishwashing area of the main kitchen was covered with a sheet of plastic to prevent the alarm from sounding and a large fan in the dishwasher area was soiled with accumulated dust and insect carcasses. These	K 130		

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K 130	Continued From page 2 findings were observed in the presence of Employee #1. The findings include: 1. The smoke detector located in the washing area of the main kitchen was improperly covered with sheet of plastic to prevent the alarm from sounding when temperatures are elevated in the dishwasher area in one (1) of one (1) observation at 9:20 AM on June 30, 2008. 2. A large overhead fan adjacent to the dishwasher was soiled with accumulated dust on the blade and cover surfaces and wall surfaces adjacent and below the fan were soiled with insect carcasses in one (1) of one (1) observation at 9:25 AM on June 30, 2008.	K 130	**K 130 NFPA 101** 1. Corrective Action for Residents Affected by Deficient Practice: No resident(s) was(were) negatively impacted. The plastic was removed from the detector in the dish machine room. The large fan was cleaned thoroughly. 2. Method to Identify Other Residents At Risk for Deficient Practice: All smoke detectors in the kitchen area and dish machine room were checked an no others were found to be covered. Other fans in kitchen area were checked and cleaned if needed. 3. Measures or Systemic Changes to Ensure Deficient Practice Does Not Recur: • Re-educate staff on observation/cleaning of fan and fan coil surfaces, and appropriate notification to supervisor if damage or soiled surfaces are observed. Maintenance to clean/repair. • Bay City Pest control contractor notified to increase checks in dish machine room. • Roof mounted exhaust fan scheduled for install in dish machine room to draw excess steam and moisture from room. • On a monthly basis, kitchen areas will be randomly checked by Director of Dining Services to ensure deficient practice does not recur. 4. Performance Monitoring to Ensure Solutions Are Sustained: Report findings in Quarterly QA meeting. **Implementation date: July 24, 2008 and quarterly thereafter x 4 quarters.**	6/30/08 6/30/08 6/30/08 6/30/08 7/24/08