STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(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 Life Safety Code Inspection was conducted at your facility on February 24, 2012; the following findings were observed.	K 000	The Washington Home makes its best effort to operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that penetrations were observed in wall surfaces above ceiling tiles and walls were not in good condition to prohibit the passage of smoke in the event of a fire in three (3) of three (3) observations. The findings include: 1. Penetrations were observed in smoke barrier walls above ceiling tiles which would not prohibit	K 017	**K017** 1. The penetrations observed in smoke barrier walls above ceiling tiles were repaired. 2. A facility-wide inspection identified all other areas free of penetrations. 3. The Director of Plant Operations and Information Technology (IT) Manager will continue to supervise contractor compliance with facility policy prohibiting penetrations above ceiling tiles. Inspection of contractor work will be done on completion of each work project. Variances will be repaired and the IT Manager will report penetrations to the contractor as deficient work quality.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/23/12

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 017	Continued From page 1 the passage of smoke in the event of a fire in the following locations. First Floor Penetrations approximately 1 inch in diameter were observed around a conduit pipe penetrating through wall surfaces over the Electric Closet door, near the Cafeteria entrance on the First Floor in two (2) of two (2) observations at 9:25 AM on February 24, 2012. Third Floor A 2-3 inch opening was observed around conduit pipe that passed through wall surfaces in the hallway near Room 334A; in addition a piece cardboard was observed covering the opening creating an additional hazard in the event of a fire in one (1) of one (1) observation at 12:25 PM on February 24, 2012. These findings were observed in the presence of the Director of Maintenance on February 24, 2012.	K 017	4. The Director of Plant Operations will track penetration above ceiling tile occurrences and report findings to the Quality Improvement Committee quarterly. 5. Date of completion:	5/4/2012
K 018 SS=C	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.	K 018	**K018** 1. The entrance doors to rooms 335 and 358 were repaired. The plastic bag holding open the Bathing/Shower room door near room 318 was removed. 2. A facility-wide inspection of room and Bathing/Shower Room doors identified all as functioning appropriately. 3. Staff will be in-serviced on not tying doors open. Maintenance staff will inspect resident room entrance doors and Bathing/Shower Room doors during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance rounds reports and spot-check doors a minimum of monthly. 4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly. 5. date of completion:	5/4/2012

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that entrance doors failed to close without assistance when tested in two (2) of six (6) observations and a Shower Door was improperly held open with a plastic bag attached to the door in one (1) of one (1) observation. The findings include: 1. The entrance doors to Rooms 335 and 358 failed to open or close without assistance in two (2) of six (6) observations at 11:55 AM on February 24, 2012. 2. The Bathing/ Shower Room door on the Third Floor near A318 door was tied and held open with a plastic bag attached to the door knob in one (1) of one (1) observation at 11:120 AM on February 24, 2012. These findings were observed in the presence of the Director of Maintenance on February 24, 2012.	K 018		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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K 045	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that light bulbs in stairwells failed to illuminate creating a potential hazard for residents and staff exiting the building in the event of an emergency in three (3) of 12 observations. The findings include: Light bulbs within Stairwell #3 First Floor, Stairwell #3 Third Floor and Stairwell # 7 Third Floor, failed to illuminate; creating a potential hazard for staff and residents in the event of an emergency in three (3) of 12 observations between 9:15 AM and 12:30 PM on February 24, 2012. These findings were observed in the presence of the Director of Maintenance on February 24, 2012.	K 045	**K045** 1. Light bulbs failing to illuminate stairwells were replaced. 2. A facility-wide inspection of stairwells identified all stairwell light bulbs illuminating. 3. Maintenance staff will be in-serviced to inspect stairwell bulbs during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check light bulbs in stairwells a minimum of monthly. 4. The Director of Plant Operations or designee will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly. 5. Date of completion: May 4, 2012	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		

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K 050	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that unexpected Fire Drills were not conducted under varying conditions to ensure that staffs are familiar with emergency procedures in one (1) four (4) observations. The findings include: Through observation and record review it was determined that documentation was not available to substantiate that a fire drill was conducted during the second shift during the third quarter between July 2011 and September 2011 in one (1) four (4) observations at 3:05 PM on February 24, 2012. These findings were observed in the presence of the Director of Maintenance on February 24, 2012.	K 050	**K050** 1. Fire drills will be conducted at least quarterly on each shift. 2. A review of the previous 12 months identified all fire drills except the 1 drill missed between July and September 2011 were conducted. 3. A Master List of fire drills scheduled and completed will be posted in the Plant Operations Office. The Director of Plant Operations or designee will verify that fire drills are conducted a minimum of quarterly on each shift. 4. The Director of Plant Operations or designee will report compliance with the fire drill schedule to the Quality Improvement Committee monthly. 5. Date of completion:	5/4/2011
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 sprinkler heads were soiled with dust accumulation in 12 of 14 observations and the egress platform of the exit door was observed to be covered with accumulated leaves and other debris in one (1) of one (1) observation. The findings include: Second Floor 1. Sprinkler head surfaces were soiled with dust accumulation and debris in the 2B hallway near	K 130	**K130** #1, #2, #3 1. The sprinkler head surfaces identified as soiled with dust/debris were cleaned. 2. A facility-wide inspection of sprinkler heads identified that sprinkler heads were clean. 3. Maintenance staff will be in-serviced to inspect sprinkler heads during Weekly Maintenance Rounds. The Director of plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check sprinklers a minimum of monthly.	

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K 130	Continued From page 5 Room 206 in four (4) of five (5) observations and hallway near Room 211 in two (2) of three (3) observations between 9:20 AM and 11:40 AM on February 24, 2012. Third Floor 2. Sprinkler head surfaces were soiled with dust accumulation in the hallway near Room 354 in two (2) of three (3) observations at approximately 11:55 AM on February 24, 2012. 3. Sprinkler head surfaces were soiled with dust accumulation over washers in the Laundry Room in six (6) of six (6) observations at 2:07 PM on February 24, 2012. 4. The egress landing area outside of stairwell # 7 on the second floor was observed to be covered with accumulated leaves and other debris, creating a potential hazard for resident and staff exiting the area in the event of an emergency in one (1) of one (1) observation at 10:45 AM on February 24, 2011. These findings were observed in the presence of the Director of Maintenance on February 24, 2012.	K 130	4. The Director of Plant Operations or designee will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly. 5. Date of completion: May 4, 2012 #4 1. Leaves and debris were removed from the egress landing area outside stairwell #7 on the second floor. 2. An inspection of all exit areas identified all clear of debris. 3. Housekeeping will be assigned to stairwell #7 egress landing weekly. Maintenance staff will be in-serviced to inspect stairwell #7 egress landing on Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check stairwell #7 egress landing a minimum of monthly. 4. The Director of Plant Operations or designee will report inspection findings for #7 egress landing to the Quality Improvement Committee quarterly. 5. Date of completion:	5/4/2012