CBL
CAROLYN BOONE LEWIS HEALTH CARE CENTER
A Nexus Health Company
1380 Southern Avenue, S.E.
Washington, D.C. 20032
(202) 279-5880

October 10, 2014

Ms. Sharon Williams-Lewis
Department of Health
Health Regulation and Licensing Administration
Health Regulation Administration
Health Care Facilities Division
899 North Capitol Street, NE
1st Floor
Washington, DC 20002

Dear Ms. Lewis:

Enclosed please find our Plan of Correction (CMS-2567) Life Safety for the survey completed on September 9, 2014.

The enclosed Plans of Correction constitutes our allegation of compliance as of October 10, 2014.

Sincerely,

Nora J. Wellington
Interim Administrator

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/09/2014

NAME OF PROVIDER OR SUPPLIER
CAROLYN BOONE LEWIS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1380 SOUTHERN AVE SE
WASHINGTON, DC 20032

(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, record review and staff interview during the Life Safety Code Survey conducted at your facility on September 9, 2014.	K 000		
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. This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection, it was determined that the entrance doors failed to close and latch into frames without assistance. These findings were observed in the presence of Maintenance Staff. The findings include:	K 018	Carolyn Boone Lewis Health Care Center, "CBL" is filing this Plan of Correction in accordance with the compliance requirements for Federal and State regulations. This Plan of Correction constitutes the facility's written allegation of compliance for deficiencies cited. However submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nora J. Waylon
TITLE: Interim Administrator
(X6) DATE: 10/10/14

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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	095015		**09/09/2014**

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K 018	Continued From page 1 First Floor The Shower Room and Nourishment Room entrance doors failed to latch into frames when tested in two (2) of 12 observations at 9:40 AM on September 9, 2014. Third Floor The Day Room entrance doors failed to close and latch into frames without assistance when tested in two (2) of two (2) observations at 11:05 AM on September 9, 2014.	K 018	Continued From page 1 1. The shower room and nourishment room doors have been repaired. The day room entrance doors have also been repaired. 2. To identify other doors that may be affected Maintenance staff did walk through and observed all entrance doors. 3. To ensure this does not reoccur, the Director of Building Services/Maintenance in-serviced Maintenance staff on NFPA requirements and importance of having entrance doors latch into frames.	9/9/14 9/16/14 10/10/14
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 penetrations were observed in smoke barrier walls which would not prevent the passage of smoke in the event of a fire in four (4) of six (6) observations. These findings were observed in	K 025	Also we have put a system in place to have maintenance staff perform monthly inspection of doors and take corrective actions if doors failed to latch. 4. To ensure the system is monitored and maintained, the Building Services/ Maintenance manager will report to QAPI Committee monthly for 3 months for review and assessment of compliance.	Monthly & Ongoing Monthly & Ongoing & X3 Months

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K 025	Continued From page 2 the presence of Maintenance Staff. The findings include: Penetrations were observed in smoke barrier walls around water pipes, communication wires, and around ceiling tiles which would not prohibit the passage of smoke in the event of a fire as follows: Ground Level 1. A 3-4 inch penetration was observed in wall surfaces above ceiling tiles near Room G in one (1) of one (1) observation at 9:05 AM on September 9, 2014. 2. A 1-2 inch penetration was observed around a water pipe in the Laundry Room near the Linen Chute in one (1) of one (1) observation at 9:15 AM on September 9, 2014. First Floor A 2 X 4 inch penetration was observed around communication wires in the Telephone Closet near the Main Entrance in one (1) of one (1) observation at 9:30 AM on September 9, 2014. Second Floor A 2 inch penetration was observed around the standpipe that passes through floor surfaces in the Housekeeping Closet; as evidenced by visibility to the floor below in one (1) of two (2) observations at 9:55 AM on September 8, 2014.	K 025	Continued From page 2 1. The penetrations near room G above ceiling tiles and around water pipe in Laundry room on ground level; also penetration around communication wires in Telephone closet on first floor, also the penetration around the standpipe in Housekeeping closet on second floor have all been corrected. 2. To identify other areas that may be affected the Maintenance staff did a walk through and checked areas above the ceiling tiles. 3. To ensure this does not reoccur the Director of Building Services/Maintenance in-serviced Maintenance staff on NFPA requirements. Also we have put a system in place to have maintenance staff perform monthly inspection of above ceiling and to check and inspect for penetrations. 4. To ensure the system is monitored and maintained, the Building Services/ Maintenance Manager will report to QAPI Committee monthly for 3 months for review and assessment of compliance.	9/9/14 9/22/14 10/10/14 Monthly & Ongoing Monthly & Ongoing & X3 Months
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052	Continued From page 3 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview during the Life Safety Code Inspection, it was determined that mechanical water flow and signaling devices were not tested on a quarterly basis as required in one (1) of two (2) observations in accordance with requirements of the National Fire Protection Association [NFPA] 25 5.2.6. The findings include: Through a review of facility records and interview on September 9, 2014 at approximately 2:00 PM, it was determined that adequate documentation was not available to substantiate that fire alarm devices were tested on a quarterly basis. The facility has a new sprinkler and alarm system as of January 2014. A review of records revealed that a quarterly test of the sprinkler and fire alarm system was completed on March 11, 2014. However, the supporting documents	K 052	Continued From page 3	

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K 052	Continued From page 4 lacked evidence of subsequent testing. There was no evidence that the facility conducted testing of the sprinkler and fire alarm device(s) during the second quarter of 2014 in one (1) of two (2) observations at 2:40 PM on September 9, 2014. The findings were acknowledged by the Director of Maintenance	K 052	Continued From page 4 1. The testing of the sprinkler and fire alarm Devices for the second quarter of 2014 was conducted by contractor BFPE on July 1, 2014.	7/1/14
			2. To identify other devices that need quarterly or regular testing, documents have been reviewed to make sure dates for testing are in place.	9/22/14
			3. A tickler system has been put in place of advance dates for quarterly testing of the sprinkler and fire alarm devices. Building Services/Maintenance manager will call/prompt BFPE contractor with due dates for testing. Test will be documented with date testing is done.	10/10/14 & Ongoing
			4. To ensure the system is monitored and maintained, the Building Service/ Maintenance manager will report to QAPI Committee monthly for 3 months for review and assessment of compliance.	Monthly & Ongoing & X3 months