

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

PRINTED: 10/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G022</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1026 8TH STREET NE WASHINGTON, DC 20002</b>
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(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
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W 000 INITIAL COMMENTS

The facility operated by DC Health Care, Inc. is in compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.

W 000

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1026 8TH STREET NE WASHINGTON, DC 20002</b>		
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from October 17, 2012 through October 19, 2012. A sample of three residents was selected from a population of six men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at three day programs, interviews with a resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>The group home for persons with intellectual disabilities (GHPID) is in compliance with the requirements of DCMR 22, Chapter 35.</p>	I 000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE