

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/29/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>WASHINGTON, DC 20019</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
W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from 11/27/18 through 11/29/18. Three clients were selected from a population of six males with various degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>The survey findings determined that the facility was in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities. No deficiencies were cited.</p>	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>HFD03-0197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/29/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>D C HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE [REDACTED] <b>WASHINGTON, DC 20019</b>
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from 11/27/18 through 11/29/18. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews, and reviews of resident and administrative records.</p> <p>The survey findings determined that the facility was in substantial compliance with the requirements of Title 22 Public Health and Medicine Chapter 35 Group Homes for Individuals with Intellectual Disabilities.</p> <p>No deficiencies were cited.</p>	I 000		

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

PRINTED: 11/30/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/29/2018</b>
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E 000	<p><b>Initial Comments</b></p> <p>An emergency preparedness survey was conducted from 11/27/18 through 11/29/18.</p> <p>The facility was in substantial compliance with the requirements of Emergency Preparedness Requirements for Medicare and Medicaid Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).</p> <p>No deficiencies were cited.</p>	E 000		
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