

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2021
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NAME OF PROVIDER OR SUPPLIER INSPIRE REHABILITATION AND HEALTH CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW WASHINGTON, DC 20037
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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) COMPLETE DATE
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L 000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted on October 13, 2021. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Survey activities consisted of a review of 11 sampled residents. No deficiencies were identified. Resident census was 165.	L 000		
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Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

YOKATI LAKANSE

TITLE

LNHA (ADMINISTRATOR)

(X6) DATE

11/1/2021