

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CPA-054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2015
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NAME OF PROVIDER OR SUPPLIER BARKER FOUNDATION, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1066 30TH STREET NW WASHINGTON, DC 20007
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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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S 000	<p>Initial Comments</p> <p>An annual licensure survey was conducted on March 31, 2015. The survey findings were based on interview with administrators and review of personnel and administrative records, as well as the review of adoptive family records (with children) and families with completed home studies (without children).</p> <p>The sample size was twenty-nine (29) personnel records based on a census of twenty-nine (29) employees, four (4) adoptive families (with children) based on a census of seven (7), and six (6) families (without children) with completed home studies based on a census of twelve (12).</p> <p>The agency was found to be in compliance with Title 29 Chapter 16, Standards of Placement, Care, and Services.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____