

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

PRINTED: 09/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>DC HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6703 SANDY SPRINGS RD WASHINGTON, DC 20012</b>		
(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 July 23, 2013 through July 25, 2013. A sample of three clients was selected from a population of six males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with two clients' guardians, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>The facility operated by DC Health Care , Inc. is in compliance with the requirements of 42 CFR 483, Subpart 1, 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>HFD030255</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/25/2013</b>
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from July 23, 2013 through July 25, 2013. 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 in the home and three day programs, interviews with two residents' guardians, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. The survey findings revealed that the facility was in compliance with Chapter 35 regulations.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
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Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_