

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF-000923	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/15/2010
NAME OF PROVIDER OR SUPPLIER DONNA & SYLVIA THAXTON		STREET ADDRESS, CITY, STATE, ZIP CODE 938 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(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
D 000	Initial Comments A licensure survey was conducted on December 15, 2010. The findings of the survey was based on observations of the Community Residential Facility (CRF), interviews with the administrative staff, as well as a review of clinical and administrative records, including incident reports. A random sample of two residents was selected from a resident population of three residents with various medical disabilities. A thorough environmental inspection was conducted of the facility, and there were no significant deficiencies that would be life threatening to the residents and/or staff.	D 000		

Health Regulation Administration

TITLE

(X6) DATE

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

STATE FORM

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