

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CRF-000907</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/04/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEIGHBORS CONSEJO INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1622 LAMONT STREET, NW</b> <b>WASHINGTON, DC 20010</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) COMPLETE DATE
{D 000}	<p>Initial Comments</p> <p>A follow-up survey was conducted to determine compliance with your plan of correction submitted for deficiencies cited on August 1, 2013 and April 17, 2013.</p> <p>The survey findings was based on observations in the home, interviews with administrative management, and direct care staff, and a review of resident and administrative records, including incident reports.</p> <p>The survey findings determined that the community residential facility was in substantial compliance with all findings.</p>	{D 000}		

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

TITLE

(X6) DATE