

PRINTED: 06/22/2010  
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0074	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED  06/11/2010
NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2220 HARTFORD STREET, SE WASHINGTON, DC 20020		
(04) 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)	(05) COMPLETE DATE	
1 000	INITIAL COMMENTS  A re-licensure survey was conducted on 6/11/2010. A random sample of three residents was selected from a resident population of four males and two females with varying cognitive and adaptive disabilities. The findings of the survey were based on observations, staff interviews, as well as a review of the resident and administrative records, including the unusual incident reports.	1 000			
1 055	3502.14 MEAL SERVICE / DINING AREAS  Each GMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper care of cooking and serving equipment for all residents residing in the facility.  The finding includes:  During the environmental inspection on 6/11/2010, at 7:17 p.m., the interior non-stick surface of several pots was observed to be in poor condition, worn and/or rusted. The facility's Residential Coordinator (RC) was interviewed on 6/11/2010, at 7:18 p.m., and he indicated he would have the worn pots thrown out and replaced. There was no evidence presented at the time of survey to substantiate that staff had been effectively trained to care for any of the eating and cooking equipment as required by this section.	1 055	Received 7/9/10  GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002  3502.14 All old pots have been thrown, and a new set of pots purchased. Every month, the home manager will do check of all kitchen utensils, and any worn or rusted pots and pans are replaced. All staff have been trained on proper use and care of kitchen utensils, and reporting to home manager when equipment is rusted.  6/20/10		

Health Regulation Administration

*Paul Alamy*

TITLE

*Ex. Director*

(06) DATE

7/9/10

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

STATE FORM

094

06/011

if continuation sheet 1 of 0

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0874	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/11/2010
NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2820 HARTFORD STREET, SE WASHINGTON, DC 20020		
(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	
1090	Continued From page 1	1000			
1090	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each QMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure integrity of the physical environment to ensure the health and safety of its residents. [Residents #1, #2, #3, #4, #5 and #6]</p> <p>The findings include:</p> <p>On 6/11/2010, at approximately 6:45 p.m., the following deficiencies were observed:</p> <ol style="list-style-type: none"> <li>The wall near Resident #2's bed was damaged (ie scrape marks, discolorations, etc).</li> <li>The vent in Resident #2's bedroom was covered with dust.</li> <li>The dresser drawer in Resident #4's bedroom was broken and not able to shut properly.</li> <li>The wall behind the door to Resident #4's bedroom was damaged. A small hole about the size of the door handle was observed.</li> <li>The thermometer in the refrigerator read 60 degrees Fahrenheit.</li> <li>The thermometer in the deep freezer read 50 degrees Fahrenheit.</li> </ol>	1000	<p>3504.1</p> <ol style="list-style-type: none"> <li>Maintenance has been given a list of all maintenance needs, and will complete all repairs by 7/5/10</li> <li>The Vent in Resident # 2's has been cleaned.</li> <li>The dresser drawer has been repaired.</li> <li>The hole in Resident # 4's room has been repaired.</li> <li>The refrigerator thermometer has been replaced, and the temperature reads 38 degrees Fahrenheit.</li> <li>The Freezer thermometer has been replaced, and it now reads 30 degrees Fahrenheit.</li> </ol> <p>In the future, the home manager will do a monthly environmental check and submit all repair needs to the maintenance department. The QMRP will provide oversight to ensure that checks are done, and repairs completed timely. 7/5/10.</p>		

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NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2630 HARTFORD STREET, SE WASHINGTON, DC 20029		
(04) 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)	(05) COMPLETE DATE
1082	Continued From page 2	1082		
1082	3504.3 HOUSEKEEPING  Each GHMRP shall be free of insects, rodents and vermin.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an insect free environment to ensure the health and safety for six of six of its residents. [Residents #1, #2, #3, #4, #6, and #8]  The finding includes:  During the environmental inspection on 6/11/2010, at 7:05 p.m., several ants were observed crawling over the kitchen counters, cabinets and also in the breadbox. Interview with the Residential Coordinator (RC) on the same day at 7:05 p.m. revealed, he would have the exterminator return to the home to address the ants. The facility failed to ensure an insect free environment as required by this section.	1082	3504.3 Pest control inspections are done quarterly. The pest control company has been contacted to exterminate ants in the home. The home manager will ensure through daily walk through, and monthly environmental checks that as soon as pests are noted, the pest control company will be requested to take care of the problem. 6/20/10	
1088	3504.7 HOUSEKEEPING  No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area.  This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure that poisonous and/or hazardous agents are not stored or kept in a food preparation environment (kitchen).  The finding includes:  During the environmental inspection on	1088	3504.7 All cleaning agents have been removed from under the sink. All staff have been inserviced about storage of chemicals. Home manager will do daily walk through in the home to ensure that chemicals are not stored in a locked cabinet. 6/20/10	

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NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 HARTFORD STREET, SE WASHINGTON, DC 20020		
(04) 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)	(05) COMPLETE DATE	
I 006	Continued From page 3 6/11/2010, at 7:19 p.m., cleaning agents were found being stored in the cabinet below the kitchen sink. Interview with the facility's Residential Coordinator (RC) on 6/11/2010, at 7:20 p.m., revealed he would have the staff remove the cleaning agents from the kitchen and store them in their locked storage area.	I 006			
I 135	<b>3505.5 FIRE SAFETY</b>  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure a fire drill was conducted on each shift to ensure the health and safety of its residents. [Residents #1, #2, #3, #4, #5 and #6]  The finding includes:  Interview with the facility's Residential Coordinator (RC) on 6/11/2010, at approximately 3:30 p.m., revealed the GHMRP functioned with four working shifts for staff. The weekday shifts covered 11-0:00 a.m., and 3-11:00 p.m. During the weekends, the shifts run from 11-0:00 a.m., and 9-11:00 p.m. There was no evidence any fire drills were being conducted on the weekend shifts. Further interview with the RC confirmed the missing drills and he indicated he would retrain staff on the requirements.	I 135	<b>3505.5</b> A schedule for all fire drills has been established for all shifts. Home manger will ensure that drills are completed on all shifts every three months.  6/30/10.		
I 203	<b>3509.3 PERSONNEL POLICIES</b>	I 203			

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1203	Continued From page 4  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to provide all staff with a review of their written job descriptions as required by this section for seven (7) out of sixteen (16) currently employed staff. (Staff #1, #3, #5, #6 and #9)  The finding includes:  Interview with the GHMRP's Qualified Mental Retardation Professional (QMRP) and the Residential Coordinator (RC) on 6/11/2010, at approximately 5:45 p.m., confirmed seven of the sixteen staff currently employed by the GHMRP were not provided the opportunity to review and discuss their job description with management.  The GHMRP failed to secure evidence that all staff were afforded the opportunity to review their job description as required by this section.	1203		
1206	3509.6 PERSONNEL POLICIES  Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on staff interview and record review, the	1206	3509.6 Staff who do not have valid health certificates have been informed to update their health status by 7/10/10. The Human Resources Department will conduct quarterly audit of personnel records to ensure that all staff are in compliance with health regulations.  7/10/10	

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NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 HARTFORD STREET, SE WASHINGTON, DC 20028		
(24) 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)	(25) COMPLETE DATE
1206	Continued From page 5  group home for the mentally retarded person (GHMRP) failed to ensure all staff received an annual health inventory as required by this section for three (3) out of sixteen (16) currently employed staff. [Staffs #5, #14 and #15]  The finding includes:  Interview with the GHMRP's Qualified Mental Retardation Professional (QMRP) and the Residential Coordinator (RC) on 6/11/2010, at approximately 4:45 p.m., confirmed three of sixteen staff did not have a valid current health certificate and/or health inventory on file.  The GHMRP failed to secure evidence that all staff had secured the proper and necessary health screening as required by this section.	1206		
1227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  This Statute is not met as evidenced by: Based on staff interview and record review, the group home for the mentally retarded persons (GHMRP) failed to provide evidence that four (4) out of sixteen (16) staff received training in the area of first aid and cardiopulmonary resuscitation (CPR).  The finding includes:	1227	3510.5(d) All staff that have not been trained in CPR and First Aid have been scheduled to obtain their certification. This will be completed by 7/15/10. The HR department will conduct quarterly audits to ensure compliance by all staff of training needs.  7/15/10	

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1 227	Continued From page 6 Interview with the facility's Residential Coordinator (RC) and record review on 6/11/2010 at approximately 3:45 p.m., revealed four out of sixteen personnel records reviewed did not reflect the staff was certified to perform either CPR or first aid. The GHMRP's governing body failed to ensure all employed staff received training in the area of CPR and first aid.	1 227		
1 375	<b>3519.6 EMERGENCIES</b>  Each GHMRP shall document each emergency and enter the follow-up actions into the resident's permanent record, which shall be made available for review by authorized individuals.  This Statute is not met as evidenced by: Based on staff interview and record review, the group home for the mentally retarded persons (GHMRP) failed to ensure all follow-up actions were recorded after emergent care was provided for a resident.  The finding includes:  The facility failed to ensure the documentation of all follow-up actions as evidenced below.  Review of the unusual incident reports on 6/11/2010, at 10:35 a.m., revealed no investigation or any other follow-up action was documented in Resident #2, Resident #3, Resident #4 or Resident #6's records to address the emergent care they received as identified below:  1. 4/8/2010, Resident #2 fell at the home, sustained a cut on her forehead and was taken to the ER for assessment and treatment. 2. 5/28/2010, Resident #3 was taken to the ER	1 375	<b>3519.6</b>  1. Incident investigator will follow up with Resident #2's incident and provide recommendations as needed. 2. Resident #2's incident with the G-tube has been resolved, however, investigator will provide a summary of investigation, and recommendations for follow up. 3. Investigator will provide investigation summary on resident #4's ER visit for lethargy. 4. Investigation summary and recommendations will be provided on Resident #6's ER visit for excessive emesis.  Capital care has completed training of two more investigators. In the future, all incidents will be investigated in a timely manner, and recommendations made for follow up. The Incident management committee will provide oversight to ensure that incidents are investigated timely, and summaries placed on file.  7/15/10	

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1375	Continued From page 7 for pulling out his G-Tube. 3. 12/29/2009, Resident #4 sent to the ER for lethargy and difficulty eating. 4. 4/30/2010, Resident #8 was taken to the ER for excessive emesis.  Interview with the facility's Qualified Mental Retardation Professional (QMHP) and the Residential Coordinator (RC) on 6/11/2010, at approximately 6:30 p.m., confirmed the information was not on file and that the oversight would be corrected immediately.	1375		
1800	<b>3523.1 RESIDENT'S RIGHTS</b>  Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observation, staff interview, and record review revealed the group home for the mentally retarded persons (GHMRP) failed to enact and enforce the necessary measures to ensure client's rights as presented in the following citations:  The findings include:  The facility failed to ensure an effective implementation of client's rights to medical and rehabilitative care as presented in citations §3502.14, §3505.5, and §3519.6.	1800	3523.1 See 3502.14, 3505.5, and 3519.6	

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NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 HARTFORD STREET, SE WASHINGTON, DC 20009		
(K4) 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)	(K5) COMPLETE DATE
R 000	INITIAL COMMENTS  A re-scene survey was conducted on 6/11/2010. A random sample of three residents was selected from a resident population of four males and two females with varying cognitive and adaptive disabilities. The findings of the survey were based on observations, staff interviews, as well as a review of the resident and administrative records, including the unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT  The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.  This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide evidence that criminal background checks covered the seven year work and residence history of each staff prior to their start of employment for four (4) out of sixteen (16) staff. [Staffs #6, #7, #14 and #15]  The finding includes:  Record review and interview with the GHRP's Residential Coordinator (RC) on 6/11/2010, at approximately 6:25 p.m., confirmed the following deficient practices:  1. Staff #5's records reflect they either lived or worked in the state of California within the seven years prior to the screening, but the criminal background check only covered the state of Maryland.	R 125	4701.5 1. Staff # 5's criminal record will be expanded to include California where she lived within 7 years of employment. 2. Staffs #7, #14 and #15 will be expanded to include the District of Columbia where they lived within 7 years of employment. Capital care will ensure that all individuals receive background checks nationwide to cover all staff in the future. 7/10/10.	

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TITLE

(K6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  CAPITAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2930 HARTFORD STREET, SE WASHINGTON, DC 20020		
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R 125	Continued From page 1  2. Staffs #7, #14 and #15's records reflect they either lived or worked in the District of Columbia within the seven years prior to the screening, but the criminal background check only covered the state of Maryland.	R 125		