

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

PRINTED: 11/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2008
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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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) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>A monitoring survey was conducted on November 10, 2008, to determine the facility's continued compliance with the deficiencies cited during the recertification survey on June 6, 2008. The findings of the survey were based on interviews and record review, as well as a review of client and administrative records, including incident reports.</p> <p>The results of the survey determined the facility maintained compliance with the previously cited Condition of Participation in Client Protections.</p>	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Erney Stephen _____ *President* _____ *11/17/08*

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 Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2008
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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I 000	<p>INITIAL COMMENTS</p> <p>A monitoring survey was conducted on November 10, 2008, to determine the facility's continued compliance with the deficiencies cited during the relicensure survey on June 6, 2008. The findings of the survey were based on interviews and record review, as well as a review of client and administrative records, including incident reports.</p> <p>The results of the survey determined the facility maintained compliance with previously cited deficient practices.</p>	I 000		

Health Regulation Administration

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

TITLE

President

(X6) DATE

11/17/08

STATE FORM

6899

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If continuation sheet 1 of 1