

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

PRINTED: 12/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
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NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018
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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
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W 000	<p>INITIAL COMMENTS</p> <p>An initial certification survey was conducted from December 19, 2012 through December 20, 2012. A sampling of three clients was selected from a population of five females with profound intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>No federal or local licensure deficiencies were cited.</p>	W 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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: HFD03-0267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2012
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018		
(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
I 000	<p>INITIAL COMMENTS</p> <p>An licensure survey was conducted from December 19, 2012 through December 21, 2012. A sampling of three clients was selected from a population of five females with profound intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>No federal or local licensure deficiencies were cited.</p>	I 000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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