

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Regulation & Licensing Administration



Intermediate Care Facilities Division



DEC 21 2010

Lynda Richard
Director of Operations
CARECO
8555 16th Street, Suite 240
Silver Spring, Maryland 20910

RE: 6613 6th Street, N.W.

Dear Ms. Richard:

On December 9, 2010, a monitoring survey was conducted to review the adequacy of adaptive equipment being used by the individuals in your facility. The monitoring survey resulted in a determination that your facility remained in compliance with the federal and licensure requirements.

Thank you for your cooperation during this monitoring visit. If you have any questions regarding this matter, please contact Laura A. Hunte, Supervisory Health Services Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

Sharon H. Mebane
Program Manager

cc: Kenneth Cabral
Director of Quality Management
Department on Disability Services

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/09/2010
NAME OF PROVIDER OR SUPPLIER CARECO 02		STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		
(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 December 9, 2010, to review the adequacy of adaptive equipment being used by the clients residing in the facility. The facility has a residential population of five females with various levels of mental retardation.</p> <p>The findings of the survey were based on observation, interviews and record review, as well as a review of client and administrative records, including incident reports. During the survey, the facility was determined to be in substantial compliance with the federal intermediate care facility regulations at the standard level.</p>	W 000		

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

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: HFD03-0143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/09/2010
NAME OF PROVIDER OR SUPPLIER CARECO 02		STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		
(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
	<p>I 000 INITIAL COMMENTS</p> <p>A monitoring survey was conducted on December 9, 2010, to review the adequacy of adaptive equipment being used by the residents of the facility. The facility has a residential population of five females with various levels of mental retardation.</p> <p>The findings of the survey were based on observation, 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 was in substantial compliance with Title 22 DCMR, Chapter 35.</p>	<p>I 000</p>		

Health Regulation Administration

TITLE

(X6) DATE

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