

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/23/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RCM OF WASHINGTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>819 6TH STREET WASHINGTON, DC 20002</b>
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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) COMPLETE DATE
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted on July 23, 2012. A sample of two residents was selected from a population of men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>No deficiencies were cited.</p>	1 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE