

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

PRINTED: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/31/2013
NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST 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 follow-up survey was conducted from October 30, 2013 through October 31, 2013, to verify that the facility had come into compliance with the conditions of participation of client protections. Three sampled clients were selected from a population of four women with varying degrees of intellectual disabilities.</p> <p>The survey findings determined that the facility was in substantial compliance with the conditions of participation in client protections.</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 & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-265	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/31/2013
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NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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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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{I 000}	<p>INITIAL COMMENTS</p> <p>A follow-up licensure survey was conducted from October 30, 2013 through October 31, 2013, to verify that the facility had come into compliance with local licensure requirements. Three sampled residents were selected from a population of four women with varying degrees of intellectual disabilities.</p> <p>The survey findings determined that the facility was in substantial compliance with local licensure requirements.</p>	{I 000}		
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Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____