

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF-000923	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2013
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NAME OF PROVIDER OR SUPPLIER DONNA & SYLVIA THAXTON	STREET ADDRESS, CITY, STATE, ZIP CODE 938 LONGFELLOW STREET NW WASHINGTON, DC 20011
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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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D 000	<p>Initial Comments</p> <p>A licensure survey was conducted on November 19, 2013. A sample of two residents was selected from a population of two males with varying degrees of physical disabilities.</p> <p>The findings of the survey were based on observations in the home, interviews with both residents, direct support staff (same as the administrative staff), and a nurse practitioner from the home call support services program, as well as a review of resident and administrative records, including incident reports.</p> <p>At the time of the survey, the facility was found to be in compliance with Title 22 DCMR, Chapter 34, Community Residents Facilities (CRF) Regulations. There were no deficiencies cited.</p>	D 000		
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Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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