

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

PRINTED: 04/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/04/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VOLUNTEERS OF AMERICA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 STANTON ROAD, SE WASHINGTON, DC 20020</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) COMPLETION DATE
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>An initial certification survey was conducted on April 2, 2013 through April 4, 2013. A sample of three clients was selected from a population of six females with varying degrees of 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 two day programs. Interviews were conducted with direct support staff, nursing and administrative staff, and the day program staff. Client and administrative records were reviewed, including incident reports.</p> <p>The survey revealed the facility was in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.</p> <p>No deficiencies were cited.</p>	W 000		
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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:  <b>HFD03-0272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/04/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>VOLUNTEERS OF AMERICA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 STANTON ROAD, SE WASHINGTON, DC 20020</b>		
(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
1 000	<p><b>INITIAL COMMENTS</b></p> <p>A follow-up licensure survey was conducted on April 2, 2013 through April 4, 2013, to determine whether the group home for individuals with intellectual disabilities (GHIID) was in compliance with Chapter 35 of Title 22, of the District of Columbia Municipal Regulations.</p> <p>The findings of the survey were based on interviews with administrative staff, the review of the personnel records for all employees and contracted professionals, review of the facility's policies and procedures manual, and an inspection of the interior and exterior of the group home for individuals with intellectual disabilities (GHIID). The survey revealed the facility was in substantial compliance with the requirements.</p> <p>No deficiencies were cited.</p>	1 000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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