

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SVCS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>39 PEABODY STREET NE WASHINGTON, DC 20011</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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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted on May 8, 2013 through May 9, 2013. A random sample of three residents was selected from a resident population of three males and two females with varying degrees of intellectual disabilities.</p> <p>The survey findings was based on observations in the home, interviews with administrative management, nursing and direct care staff, and the 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 35 (Group Homes Regulations). There were no deficiencies cited.</p>	I 000		
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TITLE

(X6) DATE

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