

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD12-0043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/23/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WARD &amp; WARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>823 FERN PL, NW WASHINGTON, DC 20012</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 September 23, 2013. A sample of two residents was selected from a population of three males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home, interviews with clients, one guardian, direct support staff, nursing and administrative staff, as well as a review of client 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, Community Residents Facilities (CRF) Regulations. There were no deficiencies cited.</p>	1 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_