PRINTED: 10/25/2011 FORM APPROVED

(X6) DATE

Health Regulation & Licensing Administration

		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 08/25/2011	
NAME OF PROVIDER OR SUPPLIER  METHODIST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE AG CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETE  DATE	
L 000		vas conducted on Augus rviews, review of record vere no deficiencies		L 000			

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

STATE FORM 6899 CP8211 If continuation sheet 1 of 1

TITLE