Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CRF-000038	A. BUILDING: _____ B. WING _____	06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRAHAM & LAURA LISNER HOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

(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
D 000	Initial Comments An annual survey was conducted at your agency from June 11, 2013, to determine compliance with Title 22 DCMR, Chapter 34 (Community Residence Facilities). The findings of the survey were based on a random sample of three (3) clinical records based on a (census of 11) patients and three (3) personnel files based on a (census of one 21) employees, observations, staff and employee interviews. There were no deficiencies cited during this annual survey.	D 000		