

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2019
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NAME OF PROVIDER OR SUPPLIER THE METHODIST HOME OF DC- FOREST HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE NW WASHINGTON, DC 20008
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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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R 000	<p>Initial Comments</p> <p>An annual licensure survey was conducted on 02/06/19 to determine compliance with Assisted Living Law "DC Code 44-101.01." The Assisted Living Residence provided care for 27 residents and employed 19 personnel to include professional and administrative staff. The findings of the survey were based on observations, record reviews, and interviews. The survey findings determined that the facility was in substantial compliance with DC Code 44-101.01, and no deficiencies were cited.</p>	R 000		
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Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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