

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INGLESIDE AT ROCK CREEK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3050 MILITARY ROAD NW WASHINGTON, DC 20015</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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R 000	<p>Initial Comments</p> <p>An annual survey was conducted from August 5, 2014, through August 6, 2014, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. "</p> <p>The Assisted Living Residence (ALR) provides care for thirty -seven (37) residents and employs forty-four (44) employees to include professional and administrative staff. The findings of the survey were based on observation, record reviews, and interviews.</p> <p>At the time of the survey, the facility was found to be in compliance with the Assisted Living Law "DC Code § 44-101.01". There were no deficiencies cited.</p>	R 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE