

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/26/2015
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NAME OF PROVIDER OR SUPPLIER LISNER LOUISE DICKSON HURT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5425 WESTERN AVENUE NW WASHINGTON, DC 20015
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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
R 000	<p>Initial Comments</p> <p>An annual survey was conducted on January 26, 2014, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. "</p> <p>The Assisted Living Residence (ALR) provides care for twenty (20) residents and employs thirty (30) employees to include professional and administrative staff. The findings of the survey were based on observations, record reviews, and interviews.</p> <p>At the time of this survey, the ALR was found to be in substantial compliance with the Assisted Living Law " DC Code § 44-101.01. "</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____