

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 02/25/2015
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NAME OF PROVIDER OR SUPPLIER THE METHODIST HOME OF THE DISTRICT OF	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 February 25, 2015 to determine compliance with the Assisted Living Law "DC Code § 44-101.01."</p> <p>The Assisted Living Residence (ALR) provides care for thirty (30) residents and employs approximately 20 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 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 _____