Health Regulation 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 _____	06/10/2010

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 Surveyor: DC007 A licensure survey was conducted from June 9, 2010 through June 10, 2010. The findings of the survey were based on observations of the Community Residential Facility (CRF), interviews with the administrative staff and residents, as well as a review of clinical and administrative records, including incident reports. A random sample of three (3) residents was selected based on a census of thirteen (13) with various medical disabilities, and three (3) personnel files based on a census of sixteen (16). A thorough environmental inspection was also conducted of the facility and there were no deficiencies found at the time of this inspection.	D 000		