

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRAND OAKS ASSISTED LIVING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5901 MACARTHUR BLVD NW WASHINGTON, DC 20016</b>		
(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 licensure survey was conducted on May 15, 2013, to determine compliance with Assisted Living Law " DC Code § 44-101.01 ". A random sample of five (5) resident records from a census of 167 patient records and five (5) staff from a census of 198 were reviewed.</p> <p>Based on observations, record reviews, patient and staff interviews, it was determined that the facility was in compliance with local licensure requirements and no deficiencies were identified.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1