

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 01/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LISNER LOUISE DICKSON HURT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5425 WESTERN AVENUE 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
--------------------	--	---------------	---	--------------------

R 000	Initial Comments An annual licensure survey was conducted on January 9, 2013 to determine compliance with Assisted Living Law "DC Code § 44-101.01". The facility was found to be in substantial compliance at the time of this survey based on staff and patient interviews, clinical and administrative record reviews. The sample size consisted of two (2) resident records based on a census of eleven (11) residents and two (2) employee records based on a census of thirteen (13) employees.	R 000		
-------	--	-------	--	--

Health Regulation & Licensing Administration	TITLE	(X6) DATE
--	-------	-----------

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