

Health Regulation & Licensing Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0030 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/01/2013 |
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| NAME OF PROVIDER OR SUPPLIER SUNRISE ASSISTED LIVING ON CONNECTICU | STREET ADDRESS, CITY, STATE, ZIP CODE 5111 CONNECTICUT AVE 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 |
|--------------------|--|---------------|---|--------------------|
| R 000 | <p>Initial Comments</p> <p>An initial licensure survey was conducted on July 1, 2013, to determine compliance with Assisted Living Law " DC Code § 44-101.01. There were no deficiencies based on observation, record reviews, and interviews, the facility was found to be in substantial compliance at the time of this survey. The sample size was thirteen (13) employee records based on a census of one hundred sixty-three (163) employees.</p> | R 000 | | |

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

TITLE

(X6) DATE