

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CRF000957	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/21/2013
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NAME OF PROVIDER OR SUPPLIER HARVARD KNOLLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2628 4TH STREET NE WASHINGTON, DC 20002
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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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D 000	<p>Initial Comments</p> <p>An on-site monitoring visit was conducted on November 21, 2013, Upon several attempts to gain entry of the community residential facility (CRF), the administrator was contacted via telephone.</p> <p>Interview with the administrator on November 21, 2013, at 9:35 a.m. revealed that her business was not operational due to a lack of admissions. Surveyor will recommend a second 90-day provisional license.</p>	D 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____