

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/14/2014
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NAME OF PROVIDER OR SUPPLIER THE METHODIST HOME OF THE DISTRICT OF	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 CONNECTICUT AVENUE 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 annual licensure survey was conducted on January 14, 2014 to determine compliance with the Assisted Living Law "DC Code § 44-101.01."</p> <p>The assisted living residence (ALR) provides personal care services to eight (8) residents and employs seventeen (17) individuals to include licensed practical nurses (LPN), a registered nurse, (RN) and certified nurses' aides (CNA). The findings of the survey were based on review of three (3) clinical records, four (4) employee records, administrative records, observations and interview with residents and staff.</p> <p>At the time of the survey, the facility was found to be in compliance with the Assisted Living Law "DC Code § 44-101.01". There were no deficiencies cited.</p>	R 000		

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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