

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR-0028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/16/2013</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOME OF DC-FOREST SIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 MILITARY ROAD NW WASHINGTON, DC 20015</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 16, 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 clinical and administrative record reviews and staff interviews. The sample sizes were three (3) resident records based on a census of twenty-nine (29) residents and three (3) employee records based on a census of thirty (30) employees.</p>	R 000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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