

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2014
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NAME OF PROVIDER OR SUPPLIER JOYE ASSISTED LIVING SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE NE WASHINGTON, DC 20017
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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 survey was conducted from September 10, 2014, through September 11, 2014, to determine compliance with the Assisted Living Law " DC Code § 44-101.01. "</p> <p>The Assisted Living Residence (ALR) provides care for eight (8) residents and employs five (5) employees to include professional and administrative staff. The findings of the survey were based on observation, record reviews, and interviews.</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		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____