

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR-0001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/15/2012
NAME OF PROVIDER OR SUPPLIER THE ARMY DISTAFF FOUNDATION INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 OREGON AVENUE NW WASHINGTON, DC 20015		
(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 October 15, 2012, to determine compliance with Assisted Living Law " DC Code § 44-101.01 ". The facility was found to be substantial compliance at the time of this survey based on clinical and administrative record reviews, staff, and patient interviews. The sample size were five (5) resident records based on a census of thirty-eight (38) residents, and five (5) employee records based on a census of twenty-six (26) employees.</p> <p>In addition, an environmental inspection was completed of the facility and there were no deficiencies that would be life threatening to the residents and/or staff.</p> <p>There were no deficiencies cited.</p>	R 000		

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TITLE

(X6) DATE

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