Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HSA-0010	A. BUILDING: _____ B. WING _____	R 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL HEALTHCARE ASSOC DBA CAPITAL	4900 MASSACHUSETTS AVENUE, NW WASHINGTON, DC 20016

(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	9900 General Provisions 9900 General Provisions An unannounced follow-up survey was conducted virtually from 10/18/2021 through 10/19/2021 to determine compliance with Title 22B DCMR, Chapter 99. The Home Support Agency provided care for six clients and employed 15 staff to include professional and administrative staff. A sample of six active client records and one personnel record was selected for review. The findings of the survey were based on client and administrative record reviews and one staff interview. The Home Support Agency was found to be in substantial compliance with Title 22B DCMR, Chapter 99.	R 000		

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