

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0088</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/21/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFELINE, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1615 KENILWORTH AVENUE, NE WASHINGTON, DC 20019</b>
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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
H 000	<p><b>INITIAL COMMENTS</b></p> <p>An initial survey was conducted from September 20, 2017, to September 21, 2017, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency Regulations). The home care agency provides home care services to five (5) patients and employs eighteen (18) staff. The findings of the survey were based on a review of administrative records, five (5) active patient records, six (6) employee records and five (5) home visits.</p> <p>The agency was found to be in substantial compliance. No deficiencies were cited.</p>	H 000		

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