Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HCA-0020	A. BUILDING _____ B. WING _____	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDSTAR HEALTH VISITING NURSE ASSOCI/	4455 CONNECTICUT AVENUE, NW, SUITE B500 WASHINGTON, DC 20008

(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	INITIAL COMMENTS An annual licensure survey was conducted from December 20, 2011, through December 22 , 2011, to determine compliance with Title 22 DCMR, Chapter 39. The findings of the survey were based on a random sample of nine(9) active clinical records based on a census of three hundred forty- five(345) patients, two (2) discharge records, ten (10) personnel files based on a census of fifty-two(52) employees and three (3) home visit. The findings of the survey were based on staff and patient interviews , review of clinical records and observations. There were no deficiencies noted and Home Care Agency was found to be substantial compliance at the time of this survey.	H 000		