(X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   (X2) MULTIPLE	Health Re	egulation & Licensir	ng Administration		<u> </u>		(VO) DATE (	SUDVEY
HCA-0054    B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE			R/CLIA MBER			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  VMT HOME HEALTH AGENCY  (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  H 000 INITIAL COMMENTS  On June 12, 2012 a licensure survey was completed. The survey determined the agency was in substantial compliance with Title 22 of the C. C. Municipal Regulations, Chapter 39. No	AND PLAN O	F OURNEU HON	IDENTIFICATION NO	W.			· [	
NAME OF PROVIDER OR SUPPLIER  VMT HOME HEALTH AGENCY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  H 000 INITIAL COMMENTS  On June 12, 2012 a licensure survey was completed. The survey determined the agency was in substantial compliance with Title 22 of the C. C. Municipal Regulations, Chapter 39. No			HCA-0054				06/	12/2012
WASHINGTON, DC 20001  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  H 000 INITIAL COMMENTS  On June 12, 2012 a licensure survey was completed. The survey determined the agency was in substantial compliance with Title 22 of the C. C. Municipal Regulations, Chapter 39. No	NAME OF PE	ROVIDER OR SUPPLIER		1		TATE, ZIP CODE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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TITLE

If continuation sheet 1 of 1

(X6) DATE