

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2016
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HOME HEALTHCARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 12TH STREET, SE WASHINGTON, DC 20003		
(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>INITIAL COMMENTS</p> <p>An initial survey was conducted from November 18, 2016 through November 21, 2016, to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22 B DCMR Chapter 39). The home care agency provides home care services for five (5) patients and employs seven (7) staff to include professional and administrative staff. The findings of the survey were based on a review of administrative records, five (5) active patient records, five (5) employee records, five(5) home visits and interviews with patients/family and staff.</p> <p>At the time of the survey, the agency was found to be in substantial compliance.</p>	H 000		

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

TITLE

(X6) DATE