

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2018
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NAME OF PROVIDER OR SUPPLIER IMMACULATE HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2512 24TH STREET, NE WASHINGTON, DC 20018
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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
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H 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted from 01/16/18 through 01/22/18, 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 287 patients and employs 572 staff including professional and administrative staff. The findings of the survey were based on a review of administrative records, fifteen (15) incident reports, fifteen (15) active patient records, five (5) discharged patient records, twenty-eight (28) employee records, five (5) home visits and (10) telephone interviews with patients/family and staff.</p> <p>No deficiencies were identified.</p>	H 000		
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Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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