

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HCA-0008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAXIM HEALTHCARE SERVICES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6856 EASTERN AVENUE, NW, SUITE 220 WASHINGTON, DC 20012</b>		
(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 annual survey was conducted from March 6, 2014, through March 7, 2014, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to twenty three (23) patients and employs one hundred and fifteen (115) staff. The findings of the survey were based on observations, record reviews and interviews with current patients and staff.</p> <p>The agency was in substantial compliance with Title 22 DCMR, Chapter 39 Home Care Agencies Regulations.</p>	H 000			

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

TITLE

(X6) DATE