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-0105	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES, INC	1100 NEW JERSEY AVENUE, 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	INITIAL COMMENTS An annual survey was conducted on 04/11/2023 through 04/14/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 76 patients and employed 167 staff. The findings of the survey were based on the review of administrative records, ten active patient records, five discharged patient records, 23 personnel records, and a review of the agency's response to complaints and incidents received. The agency was in substantial compliance with Title 22B DCMR, Chapter 39 Home Care Agency Regulations, no deficiencies were identified.	H 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE