

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2015
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NAME OF PROVIDER OR SUPPLIER BERHAN HOME HEALTH CARE AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 7825 EASTERN AVENUE, NW, SUITE L1-16 WASHINGTON, DC 20012
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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
H 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted from March 18, 2015, through March 19, 2015, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to five hundred (500) patients and employs seven hundred-five (705) employees to include professional and administrative staff. The findings of the survey were based on observations, record reviews and interviews with patient's families and staff. 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 _____