

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AMERICARE-IN-HOME NURSING CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 ALBEMARLE STREET, NW, 2ND FLOOR WASHINGTON, DC 20016
---	---

(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 Licensure survey was conducted from January 13, 2015, through January 15, 2015, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to fifty (50) patients and employs fifty (50) 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		
-------	---	-------	--	--

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------