

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 12/04/2015
--------------------------------------------------	---------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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 survey was conducted from December 3, 2015 through December 4, 2015 to determine compliance with the District of Columbia's Home Care Agency Regulations (Title 22B DCMR Chapter 39). The Home Care Agency provides home care services to eighty-eight (88) patients and employs twenty-one (21) staff. The findings of the survey were based on a review of nine (9) active patient records, one (1) discharged patient record, ten (10) employee records, four (4) home visits and interviews with patients/family and staff.</p> <p>There were no deficiencies identified during the survey. The agency was found to be in compliance with Title 22 B Chapter 39, for Home Care Agencies.</p>	H 000		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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