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-0002	A. BUILDING: _____ B. WING _____	08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING SERVICES OF D	6031 KANSAS AVE NW WASHINGTON, DC 20002

(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 from 08/08/18 through 08/08/18 to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency's Regulations). The home care agency provides home care services to one patient and employs three staff. The findings of the survey were based on a review of administrative record, no complaints or incident reports, one active patient record, four discharged patient records, and three personnel records. The agency was in substantial compliance with Title 22B DCMR, Chapter 39 Home Care Agencies Regulations, no deficiencies were identified.	H 000		

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