

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/15/2018
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NAME OF PROVIDER OR SUPPLIER HSC HOME HEALTH CARE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1731 BUNKER HILL ROAD, NE WASHINGTON, DC 20017
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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 June 12, 2018 through June 15, 2018 to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agency's Regulations). The home care agency provides home care services to 78 patients and employs 180 staff. The findings of the survey were based on a review of administrative records, four complaints, three incident reports, eight active patient records, two discharged patient records, and 15 personnel records. The findings were also based on five home visits, ten telephone interviews and interview with staff.</p> <p>The agency was in substantial compliance with Title 22B DCMR, Chapter 39 Home Care Agencies Regulations, no deficiencies were identified.</p>	H 000		

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