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-0014	A. BUILDING: _____ B. WING _____	01/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDEAL NURSING SERVICES, INC	820 UPSHUR 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	INITIAL COMMENTS An annual survey was conducted from December 29, 2015, through January 5, 2016, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to three hundred and sixty-seven (367) patients and employs six hundred and twenty-five (625) staff. The findings of the survey were based on observations, record reviews and interviews with current patients and staff. The agency was in substantial compliance with Title 22B DCMR, Chapter 39 Home Care Agencies Regulations.	H 000		

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