

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HCA-0015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER POTOMAC HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5255 LOUGHBORO COMMUNITY SERVICE BLDG WASHINGTON, DC 20016
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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
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H 000	<p>INITIAL COMMENTS</p> <p>An annual survey was conducted from January 20, 2016, through January 28, 2016, to determine compliance with Title 22B DCMR, Chapter 39 (Home Care Agencies Regulations). The Home Care Agency provides home care services to eighty three (83) patients and employs eighteen (18) 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 22B DCMR, Chapter 39 Home Care Agencies Regulations.</p>	H 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____