

Health Regulation 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 06/15/2010
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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	PRDVIDER'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 at your agency on June 8, 2010, through June 11, 2010, to determine compliance with Title 22 DCMR, Chapter 39 (Home Care Agencies Regulations). The findings of the survey were based on a random sample of seven(7) active clinical records based on a census of sixty (60) patients, one (1) discharged clinical record, eight(8) personnel files based on a census of forty(40) employees and two(2) home visits. Your facility was found to be in substantial compliance at the time of this survey.</p>	H 000		

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM