IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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February 25, 2015

Joe Frasure, Administrator
Aspen Home Care
2867 E Copperpoint Dr
Meridian, ID 83642

RE: Aspen Home Care, CCN #137091

Dear Mr. Frasure:

This is to advise you of the findings of the Medicare/Licensure survey of Aspen Home Care, which was concluded on February 12, 2015.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states no deficiencies were identified and the Aspen Home Care was found in full compliance with all Conditions of Participation. A similar form stating no state licensure deficiencies were identified is also enclosed.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call this office at (208) 334-6626, option 4.

Sincerely,

LAURA THOMPSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LT/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137091	A. BUILDING _____ B. WING _____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOME CARE	2867 E COPPERPOINT DR MERIDIAN, ID 83642

(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) COMPLETION DATE
G 000	INITIAL COMMENTS A Medicare recertification survey was conducted at your home health agency from 2/10/15 to 2/12/15. The agency was found in full compliance with 42 CFR 484 Conditions of Participation for Home Health Agencies. Surveyors conducting the survey were: Laura Thompson, RN, HFS, Team Lead Susan Costa, RN, HFS	G 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 000	INITIAL COMMENTS A state licensure survey was conducted at your home health agency from 2/10/15 to 2/12/15. No deficiencies were identified. Surveyors conducting the survey were: Laura Thompson, RN, HFS, Team Lead Susan Costa, RN, HFS	G 000		

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

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