IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN– Director

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 28, 2019

Kristi Lauck, Administrator
Multicare Home Health Services, Inc
P.O Box 355
Meridian, ID 83680

RE: Multicare Home Health Services, Inc, Provider #137093

Dear Ms. Lauck:

On March 18, 2019, a follow-up visit of your facility, Multicare Home Health Services, Inc, was conducted to verify corrections of deficiencies noted during the survey of December 28, 2018.

We were able to determine that the Condition of Participation of:
42 CFR § 484.60 Care Planning, Coordination, Quality Of Care is now met.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

Dennis Kelly RN, Supervisor
Non-Long Term Care

DK/dk
Enclosures
ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137093	A. BUILDING _____ B. WING _____	R 03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICARE HOME HEALTH SERVICES, INC	**324 SOUTH MERIDIAN RD, SUITE 10 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 follow up survey was conducted at your home health agency on 3/18/19. The agency was found to be in full compliance with 42 CFR 484. The surveyors conducting the survey were: Nancy Bax RN, BSN, HFS - Team Leader Brian Osborn, RN, HFS James Brown, RN, HFS	{G 000}		

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

03/28/2019

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.