IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

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June 8, 2019

Melinda Williams, Administrator
Intermountain Home Care Of Cassia
1031 E Main Street
Burley, ID 83318-2029

RE: Intermountain Home Care Of Cassia, Provider #137016

Dear Ms. Williams:

On June 4, 2019, a follow-up visit of your facility, Intermountain Home Care Of Cassia, was conducted to verify corrections of deficiencies noted during the survey of April 18, 2019.

We were able to determine that the Conditions of Participation of **Conditions of Participation of Care Planning, Coordination, and Quality of Care; and Skilled Professional Services (42 CFR NUMBER 484.60; and 42 CFR NUMBER 484.75)** are 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

DENNIS KELLY, RN, Supervisor
Non-Long Term Care
DK/slj
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
	137016	A. BUILDING _____ B. WING _____	R 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOME CARE OF CASSIA	1031 E MAIN STREET BURLEY, ID 83318

(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 certification follow-up survey was conducted at your home health agency on 6/04/19. The agency was found to be in substantial compliance with 42 CFR 484. The surveyors conducting the survey were: Weslianne Lewis, RN, BSN, HFS - Team Leader James Brown, RN, HFS	{G 000}		
{E 000}	Initial Comments There were no deficiencies cited during the Medicare recertification follow-up survey of your hospice from 6/03/19 to 6/04/19, and your agency was in substantial compliance with CMS Emergency Preparedness rules. Surveyors conducting the survey were: Weslianne Lewis, RN, BSN, HFS, Team Lead James Brown, RN, HFS	{E 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.