

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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January 18, 2012

Matthew Hoskins, Administrator
Touchmark Home Health
PO Box 764
Meridian, ID 83680

RE: Touchmark Home Health, Provider #137092

Dear Mr. Hoskins:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your facility, Touchmark Home Health, on January 11, 2012.

Enclosed are a Statement of Deficiencies/Plan of Correction, Form CMS-2567 and a State Licensure Statement of Deficiencies/Plan of Correction which state that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208) 334-6626.

Sincerely,

KAREN ROBERTSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRÉSWELL
Co-Supervisor
Non-Long Term Care

KR/srm
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2012
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NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642
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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) COMPLETION DATE
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G 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the Medicare recertification survey of your home health agency. Touchmark Home Health is in compliance with 42 CFR 484, Conditions of Participation for Home Health Agencies.</p> <p>The following surveyors conducted the survey:</p> <p>Karen Robertson, RN, BSN, HFS, Team Leader Gary Guiles, RN, HFS</p>	G 000		
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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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2012
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NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642
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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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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>No deficiencies were cited during the state licensure survey of your home health agency. Touchmark Home Health is in compliance with the Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 07, "Rules for Home Health Agencies."</p> <p>The following surveyors conducted the survey:</p> <p>Karen Robertson, RN, BSN, HFS, Team Leader Gary Guiles, RN, HFS</p>	N 000		
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Bureau of Facility Standards

TITLE

(X6) DATE

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