



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
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PHONE 208-334-6626
FAX 208-364-1888

December 28, 2012

Michael Hull, Administrator
Loving Care And More
Po Box 119
Silverton, ID 83867

RE: Loving Care And More, Provider #137074

Dear Mr. Hull:

Congratulations on the deficiency free Medicare/Licensure survey, which was concluded at your agency, Loving Care And More, on December 13, 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,


SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care


SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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Enclosures

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

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/13/2012
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NAME OF PROVIDER OR SUPPLIER LOVING CARE AND MORE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 WINDRIVER ROAD SILVERTON, ID 83867
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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)	(X6) COMPLETION DATE
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G 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the recertification survey of your home health agency. Loving Care and More was in compliance with 42 CFR part 484, Conditions of Participation: Home Health Agencies. The surveyors conducting the on-site visit were:</p> <p>Susan Costa, RN, HFS, Team Leader Sylvia Creswell, LSW, Supervisor 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: OAS001330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER LOVING CARE AND MORE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 WINDRIVER ROAD SILVERTON, ID 83867		
(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)	(X6) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS No deficiencies were cited during the state licensure survey of your home health agency. Loving Care and More was in compliance with IDAPA 16.03.07: Rules for Home Health Agencies. The surveyors conducting the on-site visit were: Susan Costa, RN, HFS, Team Leader, Sylvia Creswell, LSW, Supervisor Gary Gules, RN, HFS	N 000		

Bureau of Facility Standards

TITLE

(X6) DATE

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