IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
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November 27, 2019

Catherine Jerrems, Administrator
First Choice Home Care
12400 West Overland Road, Suite 100
Boise, ID 83709-0021

RE: First Choice Home Care, Provider #137108

Dear Ms. Jerrems:

On November 25, 2019, a follow-up visit of your agency, First Choice Home Care, was conducted to verify corrections of deficiencies noted during the survey of October 4, 2019.

We were able to determine that the Condition of Participation of
42 CFR § 484.55 Comprehensive Assessment of Patients
42 CFR § 484.60 Care Planning
42 CFR § 484.70 Infection Prevention and Control
42 CFR § 484.75 Skilled Professional Services, and
42 CFR § 484.105 Organization and Administration of Services 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/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
	137108	A. BUILDING _____ B. WING _____	R 11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME CARE	**12400 WEST OVERLAND ROAD, SUITE 100 BOISE, ID 83709**

(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 There were no deficiencies cited during the Medicare Recertification follow-up survey of your agency conducted on 11/25/19. The surveyors conducting the follow-up survey were: Brian Osborn, RN, HFS Weslianne Lewis, RN, BSN, HFS Kim Mehlhaff, RN, HFS	{G 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/26/2019

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.