State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health
W. David Patton, Ph.D.
Executive Director

Division of Family Health and Preparedness
Marc E. Babitz, M.D.
Division Director

Bureau of Health Facility Licensing, Certification and Resident Assessment
Joel Hoffman
Bureau Director

LC-1149

October 12, 2012

Mr. Marty Hoelscher, Administrator
Superior Home Care Inc.
184 East 5900 South
Murray, UT 84107

Dear Mr. Hoelscher:

On October 4, 2012, the Utah Department of Health, Division of Family Health and Preparedness, Bureau of Health Facility Licensing, Certification and Resident Assessment completed a recertification survey of your Home Health Agency. The survey staff found Superior Home Care Inc. to be in compliance with the requirements for participation in the Medicare/Medicaid program as defined in Title 42 Code of Federal Regulations, Part 484 "Conditions of Participation - Home Health Agencies".

We would like to commend your agency for the quality of care provided to Medicare/Medicaid clients. Enclosed is a Statement of Deficiencies, CMS-2567 reflecting your compliance. Please sign and date this document and return it to our office within 10 days of receipt of this notice.

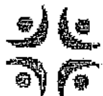
If you have any questions, please contact me at (801) 538-6158 or toll free at 1-800-662-4157.

Sincerely,

Kelly J. Criddle

Kelly J. Criddle, Manager
Hospital and Ambulatory Care Section

Enclosure



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

PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	467108	A. BUILDING ______ B. WING ______	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPERIOR HOME CARE INC	184 EAST 5900 SOUTH MURRAY, UT 84107

(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 Based on a standard recertification survey, the agency was found to be in compliance with the Conditions of Participation Code 42, Code of Federal regulations: 42 CFR 484.10 42 CFR 484.21 42 CFR 484.14 (g) 42 CFR 484.18 42 CFR 484.48 No deficiences were cited. Recertification was recommended.	G 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.