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 and Certification
Joel Hoffman
Bureau Director

September 23, 2015

Ms. Andrea Hoelscher, Administrator
Superior Home Care
184 East 5900 South
Murray, UT 84107

Dear Ms.. Hoelscher:

On September 17, 2015, the Utah Department of Health, Division of Family Health and Preparedness, Bureau of Health Facility Licensing and Certification completed a Recertification survey of your Home Health Agency. The survey staff found Superior Home Care 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. 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) 273-2994 or toll free at 1-800-662-4157.

Sincerely,

Kelly J. Griddle, Manager
Hospital and Ambulatory Care Section

Enclosure

UTAH DEPARTMENT OF HEALTH

3760 South Highland Drive, Suite 200, Salt Lake City, UT 84106
Mailing address: P.O. Box 144103, Salt Lake City, UT 84114-4103
Telephone (801) 273-2994 • Facsimile (801) 274-0658 • www.health.utah.gov

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

PRINTED: 09/21/2015
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 _____	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPERIOR HOME CARE	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 recertification survey, it was determined that Superior Home Care was found to be in compliance with the 42 Code of Federal Regulations (CFR) for home health agencies as follows: 42 CFR 484.10 42 CFR 484.11 42 CFR 484.12 42 CFR 484.14(g) 42 CFR 484.18 42 CFR 484.30 42 CFR 484.32 42 CFR 484.36 42 CFR 484.48 42 CFR 484.55 No deficient practice was identified.	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Holsclaw | TITLE: Administrator | (X6) DATE: 9/25/15

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.