



State of Utah

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**Bureau of Health Facility Licensing,  
Certification and Resident Assessment**

Allan D. Elkins  
Bureau Director

LC-1598

December 18, 2008

Mr. Richard Bennett, Administrator  
South Davis Community Hospital Home Health Agency  
401 South 400 East  
Bountiful, UT 84010

Dear Mr. Bennett:

On December 9, 2008, the Utah Department of Health, Division of Health Systems Improvement, Bureau of Health Facility Licensing, Certification and Resident Assessment completed a recertification survey of your Home Health Agency. The survey staff found South Davis Community Hospital Home Health Agency 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) 538-6158 or toll free at 1-800-662-4157.

Sincerely,

Kelly J. Criddle, Manager  
Hospital and Ambulatory Care Section

Enclosure

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

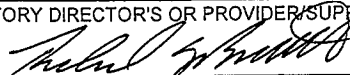
PRINTED: 12/17/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>467081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/09/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTH DAVIS COMMUNITY HOSPITAL HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH 400 EAST BOUNTIFUL, UT 84010</b>
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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><b>INITIAL COMMENTS</b></p> <p>Based on the standard recertification survey conducted 12/9/08, it was determined that South Davis Community Hospital Home Health Agency was in compliance with the 42 Code of Federal Regulations (CFR) for home health agencies as follows;</p> <p>42 CFR 484.10 42 CFR 484.11 42 CFR 484.12 42 CFR 484.14(g) 42 CFR 484.18 42 CFR 484.36 42 CFR 484.48 42 CFR 484.55</p> <p>No deficiencies were cited.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>12/22/08</b>
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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.

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

PRINTED: 04/04/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>467081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/27/2007</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTH DAVIS COMMUNITY HOSPITAL HOME HEALTH AGENCY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 SOUTH 400 EAST BOUNTIFUL, UT 84010</b>
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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><b>INITIAL COMMENTS</b></p> <p>An abbreviated survey was conducted on 3/27/07. No deficiencies were cited.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rosmarie Kirby</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/9/07</i>
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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.

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

PRINTED: 02/15/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  467081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/02/2006
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NAME OF PROVIDER OR SUPPLIER  SOUTH DAVIS COMMUNITY HOSPITAL HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH 400 EAST BOUNTIFUL, UT 84010
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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>Based on the standard recertification survey of 02/01/06 through 02/02/06, South Davis Community Hospital Home Health was found in compliance with the 42 Code of Federal Regulations (CFR) for home health agencies as follows:</p> <p>42 CFR 484.10 42 CFR 484.11 42 CFR 484.12 42 CFR 484.14 (g) 42 CFR 484.18 42 CFR 484.36 42 CFR 484.48 42 CFR 484.55</p> <p>No deficiencies were cited.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Rosemary Turbay* TITLE *Administrator* (X6) DATE *2/27/06*

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.