

Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

SUPPLIER INFORMATION

Supplier Type:

Supplier Number: 1129730001

Supplier Name: YEH'S PHARMACY II

National Provider Identifier(NPI): 1538254057

Authorized Representative: KYEUNG S YEH

Telephone Number: 3237337788

Address: 966 S WESTERN AVE STE 103

City/State/Zip Code: Los Angeles, CA 90006

Reason for Visit: Revalidation

VISIT DATES

Date of First Visit

12/21/2023



Time of First Visit

09:45 AM

Date of Second Visit



Time of Second Visit

FACILITY INFORMATION

1. Type of Facility

Storefront

- ☐ Yes
☒ No

Suite-Mall/Plaza

- ☐ Yes
☒ No

Suite-Office Building

- ☒ Yes
☐ No

Private Residence

- ☐ Yes
☒ No

Warehouse (Only)

- ☐ Yes
☒ No

Office-Warehouse Attached

- ☐ Yes
☒ No

Other

- ☐ Yes
☒ No

If "Other", Please Describe

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Date: 12/21/2023 09:41 AM PST

a. What is the approximate size of the facility?

800 square feet

b. Is access to facility restricted (gated community, call box, etc)?

- ☐ Yes
☒ No

c. Are there customers or signs of business activity during the inspection?

- ☒ Yes
☐ No

d. Is this facility normally visited by beneficiaries?

- ☒ Yes
☐ No

e. If a home based business, are all local zoning requirements met?

- ☐ Yes
☐ No
☒ N/A

2. Is the facility accessible to the disabled?

- ☒ Yes
☐ No

If "No", how does the supplier accommodate disabled persons?

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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3. Is there a permanent, visible sign with the supplier's business name posted on the facility?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0749. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244- 1850.

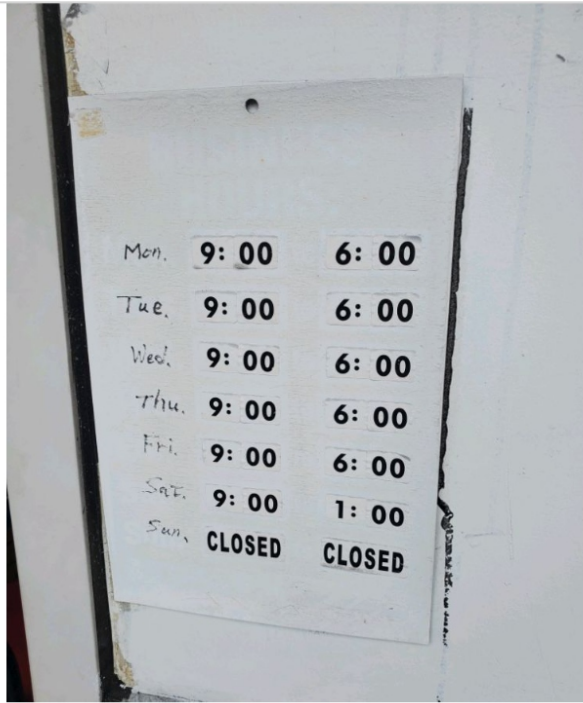
4. Are hours of operation posted?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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Open 24/7 (Open 24 hours a day, 7 days a week)

OR

☐ Yes

☒ No

By Appointment Only (no fixed days or hours)

AND/OR

☐ Yes

☒ No

Please list hours of operation below

Monday

9:00 AM to 6:00 PM

Tuesday

9:00 AM to 6:00 PM

Wednesday

9:00 AM to 6:00 PM

Thursday

9:00 AM to 6:00 PM

Friday

9:00 AM to 6:00 PM

Saturday

9:00 AM to 1:00 PM

Sunday

Closed

Total Hours

55 hours

5. Was the site visit completed? If unable to conduct site visit for any reason (supplier not operational or inspection refused), please explain in the Additional Comments section at the end of this form.

- ☒ Yes
☐ No

INTERVIEW OF INDIVIDUAL(S) PRESENT

6. Individual(s) Interviewed

- ☐ Owner
☐ President
☐ Manager
☒ Administrator
☐ Other

Owner's Last Name

Owner's First Name

President's Last Name

President's First Name

Manager's Last Name

Manager's First Name

Administrator's Last Name

Kyeung

Administrator's First Name

Yeh

If "Other", Please Describe

Additional Information

I met with the Pharmacist in Charge

7. The supplier must provide a list of all owners and management with day-to-day control, including name and title.

Attach Copy

- ☐ Yes
☒ No

8. Does the supplier have other locations that service Medicare beneficiaries? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Business Name

Address

City

State

Zip Code

PTAN

9. Does the owner or any relatives own(ed) any other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Owner's Last Name

Owner's First Name

Relationship

Business Name

Address

City

State

Zip Code

10. Does the supplier share office space with other DME suppliers or other medical businesses?

- ☐ Yes
☒ No

If "Yes", please supply the following items:

Business Name

Type of Business

Owner's Last Name

Owner's First Name

Attach Photo

- ☐ Yes
☒ No

Do the co-located businesses share any of the following items?

a. Entrances

- ☐ Yes
☐ No

b. Office personnel/ownership

- ☐ Yes
☐ No

c. EIN

- ☐ Yes
☐ No

d. Telephone

- ☐ Yes
☐ No

e. Inventory

- ☒ Yes
☐ No

If "Yes" to any of the above, please describe and attach photos.

RECORDS & TELEPHONE

11. Are the patient records maintained (check all that apply)

at this location?

- ☒ Yes
☐ No

at an off-site storage facility?

- ☐ Yes
☒ No

electronically?

- ☒ Yes
☐ No

a) Do these records include physician ordering/referral documentation?

- ☒ Yes
☐ No

b) Do these records include beneficiary communications, such as questions received from beneficiaries and progress notes?

- ☒ Yes
☐ No

c) Do these records include documentation of delivery?

- ☒ Yes
☐ No

d) Do these records include documentation of maintenance, repairs, or exchanges?

- ☒ Yes
☐ No

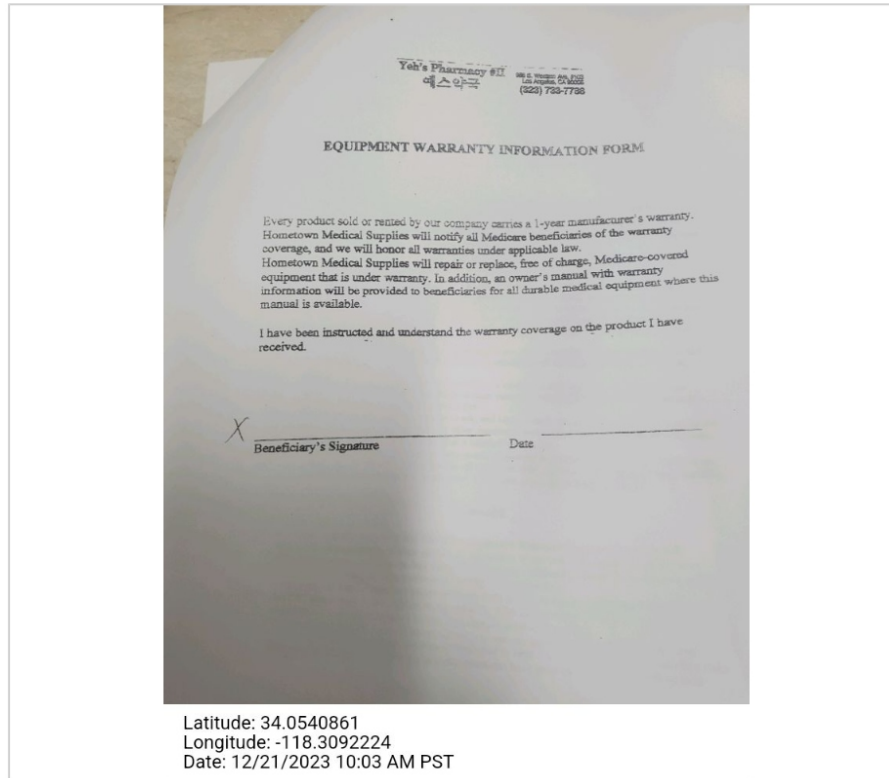
e) Do these records include proof the supplier provided equipment warranty?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



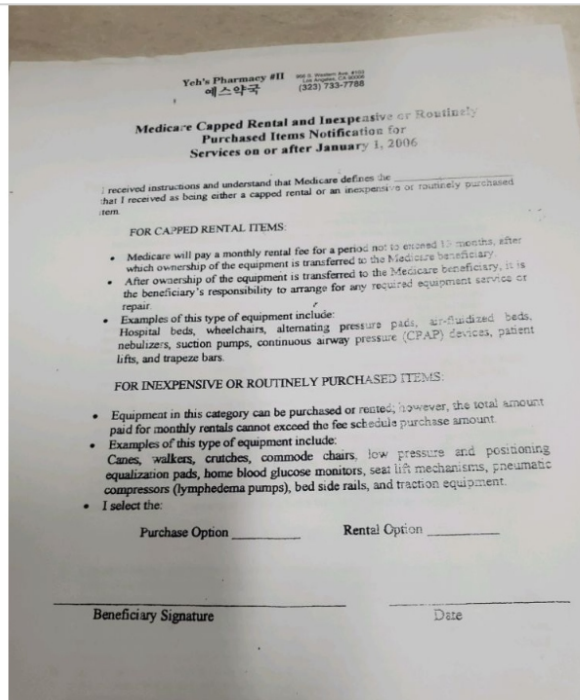
f) Do these records include proof the supplier advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the capped rental policy?

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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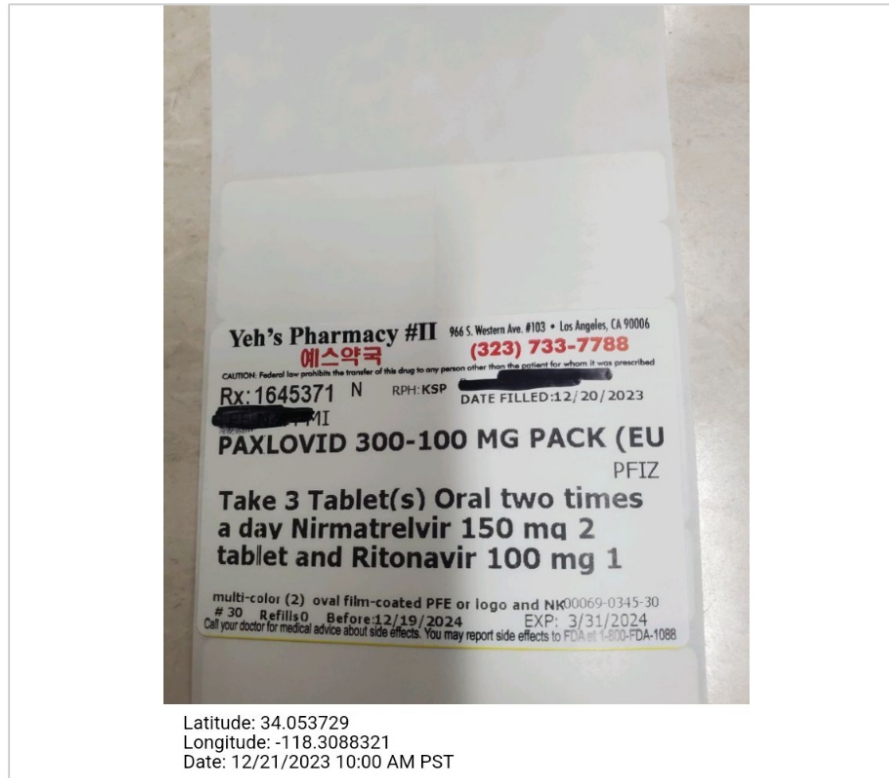
g) Do these records include proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively?

Attach Photo

☒ Yes
☐ No

☒ Yes
☐ No

Photo Upload



If "No" to any of the above, please explain

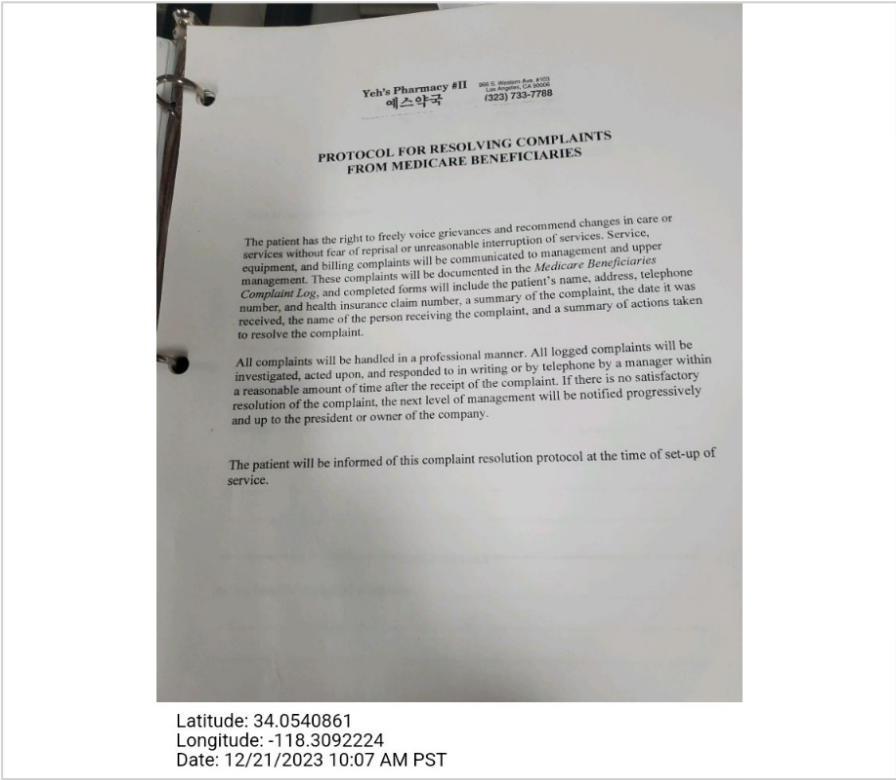
12. Does the supplier have a written complaint policy/procedure established and document for logging complaints?

- ☒ Yes
☐ No

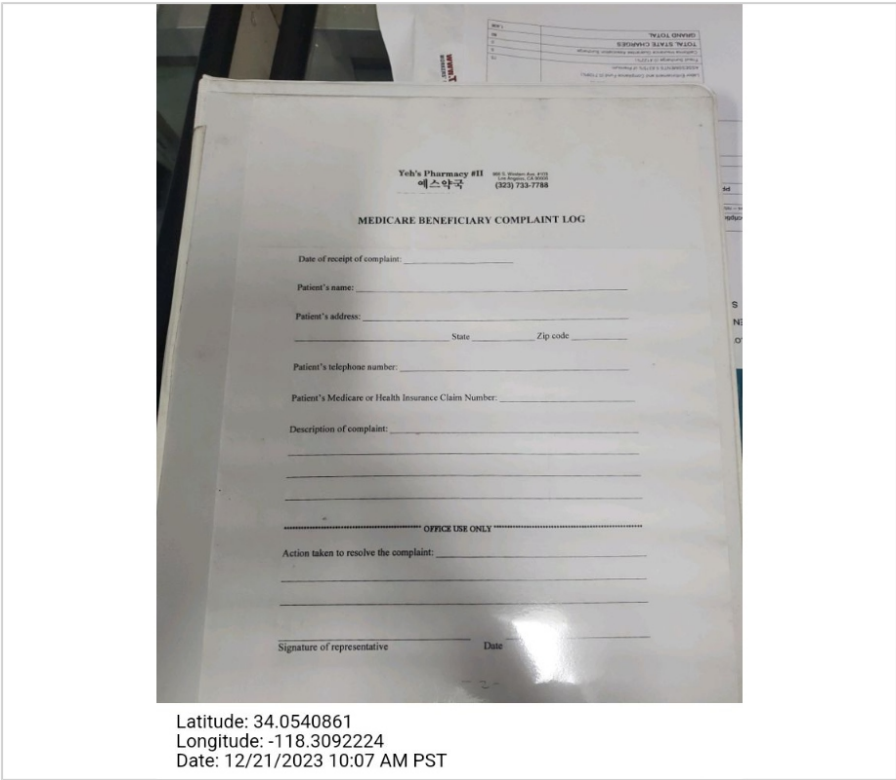
If "Yes", please attach a copy of their complaint policy and complaint log.

- ☒ Yes
☐ No

Complaint Policy Photo Upload



Complaint Log Photo Upload



13. Does the supplier have a business phone number (other than a cellular phone) listed in a local telephone directory under the business name?

- ☒ Yes
☐ No

Please list the phone number

323-733--7788

a) How was the phone number verified (check all that apply)?

White/Yellow Pages

- ☒ Yes
☐ No

Directory Assistance

- ☒ Yes
☐ No

b) Was there telephone activity during the site inspection?

- ☒ Yes
☐ No

LICENSING/CERTIFICATION

14. Are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with NSC as the certificate holder.)

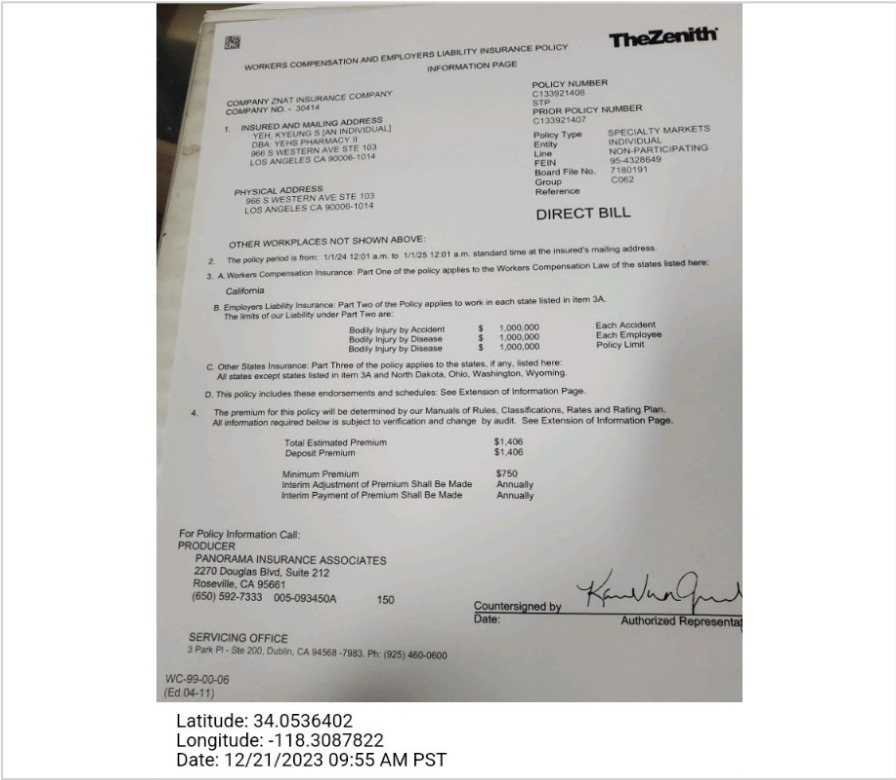
- ☒ Yes
☐ No

If "No", please describe

Attach Photo

- ☒ Yes
☐ No

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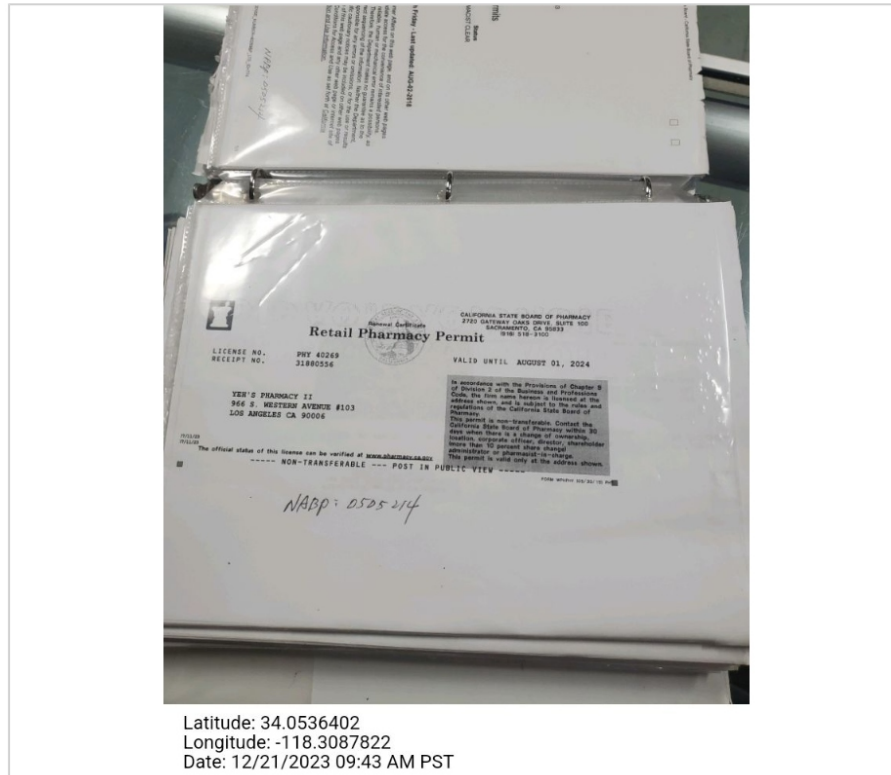
15. Does the supplier have valid state and federal licenses applicable to their business? If "No", please describe

- ☒ Yes
- ☐ No

Attach Photo

- ☒ Yes
- ☐ No

Photo Upload



16. Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items?

- ☐ Yes
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
☒ No

a) Does the supplier fabricate items onsite?

- ☐ Yes
☒ No

If "No", does the supplier contract with other companies for the purchase of items necessary to fill orders?

- ☐ Yes
☒ No

If "Yes", please identify the company:

Company Name

Street Address

City

State

Zip Code

Telephone #

17. Does the supplier provide diabetic footwear?

- ☐ Yes
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
☒ No

18. Does the supplier provide oxygen or oxygen related equipment?

- ☐ Yes
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
☒ No

INVENTORY

19. Does the supplier have inventory stored on site?

- ☒ Yes
☐ No

Briefly provide description of inventory present

The provider stated they have the following inventory; Lancets, Freestyle , Blood Glucose Meters

Attach Photo

- ☒ Yes
☐ No

Photo Upload



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20. Does the inventory present support the supplier's billing history?

- ☐ Yes
☒ No

N/A (No billing history)

Yes

a) If "No", please obtain invoices and/or contracts to verify the purchase of DME supplies.

- ☒ N/A
☐ Attach Photo

Vendor Name

Street Address

City

State

Zip Code

Telephone #

b) Does the supplier maintain an off-site storage facility?

- ☐ Yes
☒ No

If "Yes", please provide

Street Address

City

State

Zip Code

c) Does the supplier accept other types of health insurance?

- ☒ Yes
☐ No

If "Yes", please list

The provider stated they accept the following insurance; Aetna, Blue Cross, Healthnet and all Primary insurance.

21. Does the supplier rent Durable Medical Equipment?

- ☒ Yes
☐ No

a) If "Yes", does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

- ☒ Yes
☐ No

b) Do they have a service contract with another supplier?

- ☐ Yes
☒ No

If "Yes", please identify the company

- ☐ Yes
☐ No

Company Name

Street Address

City

State

Zip Code

Telephone #

If "No" to any of the above, please provide an explanation:

The provider stated they do not have any contracts with other companies.

Attach Photo

- ☐ Yes
☒ No

CONTACT WITH BENEFICIARY

22. Is a copy of the current Supplier Standards provided to all Medicare patients?

- ☒ Yes
☐ No

23. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via telephone?

- ☐ Yes
☒ No

If "Yes" to third-party vendor, list company name(s).

If "No", please describe what methods the supplier uses to obtain new customers?

Notes

The provider stated that they take walk in and doctor referrals.

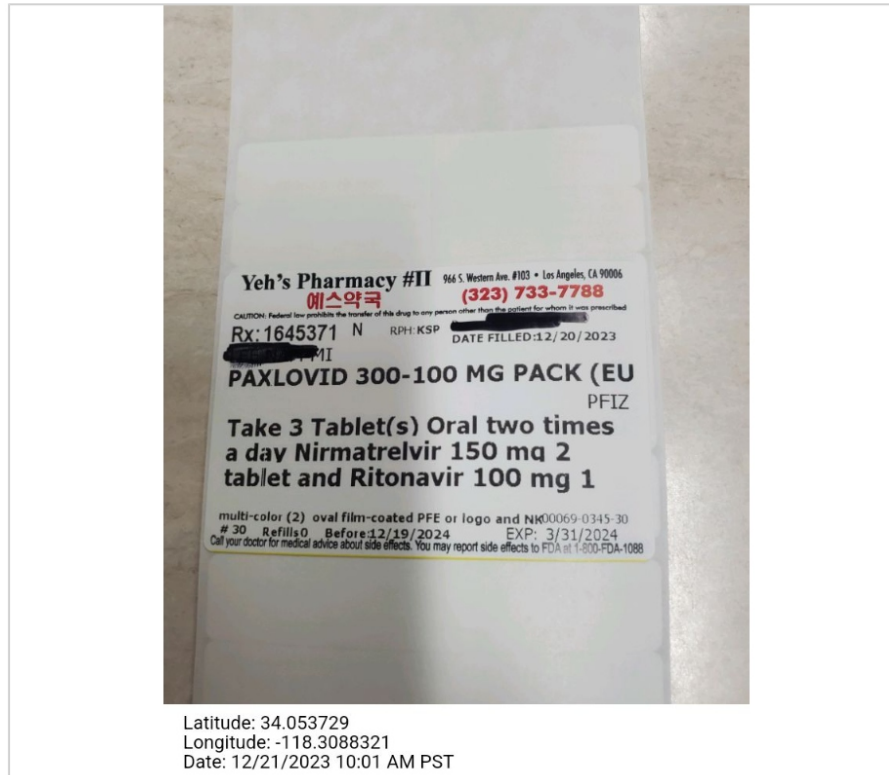
24. Does the supplier furnish contact information to beneficiaries at the time of delivery? Example: an equipment sticker label listing the supplier's name and telephone number

- ☒ Yes
☐ No

Attach Photo

- ☒ Yes
☐ No

Photo Upload



25. Does the supplier accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries?

- ☒ Yes
☐ No

If "No", explain the reasons why

SIGNATURE AND DECLARATION

Additional Comments

All photos taken have been reviewed for clarity and accuracy.

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed This On

12/21/2023



Signature of Declarant



Printed Name

Jerome Banks

Date of Inspection

12/21/2023





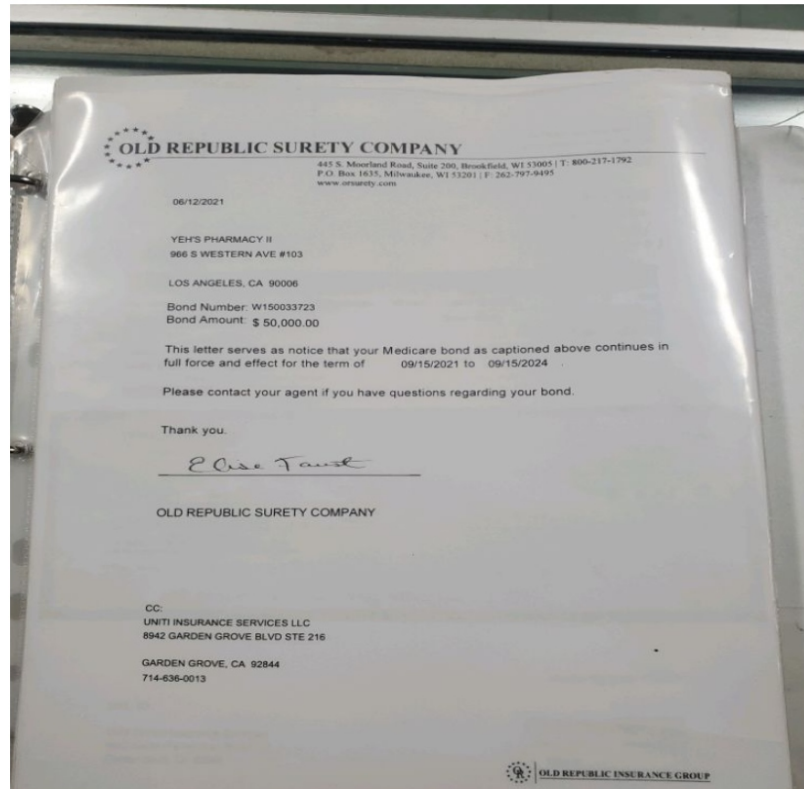
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Longitude: -118.3086487
Date: 12/21/2023 09:41 AM PST

Address



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Longitude: -118.3086487
Date: 12/21/2023 09:41 AM PST

Suite Number



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Surety Bond