



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 17, 2007

FILE COPY

Dr. Gavin Young
North Idaho Endoscopy Center
1607 Lincoln Way Suite 100
Coeur D'Alene, ID 83814

Dear Dr. Young:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, North Idaho Endoscopy Center, on January 11, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosure

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

PRINTED: 01/16/2007
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13C0001044 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/11/2007 |
|--|---|--|---|

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|--|---|
| NAME OF PROVIDER OR SUPPLIER NORTH IDAHO ENDOSCOPY CENTER, | STREET ADDRESS, CITY, STATE, ZIP CODE 1607 NORTH LINCOLN WAY, SUITE 100 COEUR D'ALENE, ID 83814 |
|--|---|

| (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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| Q 000 | <p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the Medicare recertification survey of your Ambulatory Surgical Center. North Idaho Endoscopy Center is in compliance with the requirements of 42 CFR 416, Conditions for Coverage of Ambulatory Surgical Center services. The surveyor conducting the Medicare recertification survey was Penny Salow, R.N., H.F.S.</p> | Q 000 | | |
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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.