



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

JAMES E. RISCH - Governor  
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

December 11, 2006

Lori Maupin  
Liberty Dialysis - Idaho Falls LLC  
2381 East Sunnyside Road  
Idaho Falls, ID 83404

FILE COPY

Dear Ms. Maupin:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Liberty Dialysis - Idaho Falls LLC, on November 14, 2006.

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,

GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care

SYLVIA CRESWELL  
Supervisor  
Non-Long Term Care

GG/mlw

Enclosure

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

Printed: 12/08/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13T018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/14/2006</b>
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NAME OF PROVIDER OR SUPPLIER <b>LIBERTY DIALYSIS-IDAHO FALLS, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2381 E. SUNNYSIDE RD. IDAHO FALLS, ID 83404</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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V 000	<p><b>INITIAL COMMENTS</b></p> <p>No deficiencies were cited during the initial Medicare certification survey of your dialysis facility. Liberty Dialysis-Idaho Falls, LLC, is in compliance with the requirements of 42 CFR Part 405, Conditions of Coverage for End-Stage Renal Disease Facilities. The surveyor conducting the initial Medicare certification survey was Gary Guiles, RN, HFS.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

A 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.