IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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September 11, 2018

Tom Ross, Administrator
Syringa Surgical Center
1630 23rd Avenue, Suite 902
Lewiston, ID 83501

RE: Syringa Surgical Center, Provider #13C0001054

Dear Mr. Ross:

On September 7, 2018, a follow-up visit of your facility, Syringa Surgical Center, was conducted to verify corrections of deficiencies noted during the survey of July 26, 2018.

We were able to determine that the Conditions of Participation of **Governing Body and Management (42 CFR 416.41), Quality Assessment and Performance (42 CFR 416.43) and Infection Control (42 CFR 416.41)** are now met.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures
ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001054	A. BUILDING ______ B. WING ______	R 09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYRINGA SURGICAL CENTER	1630 -23RD AVENUE, SUITE 902 LEWISTON, ID 83501

(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
{Q 000}	INITIAL COMMENTS There were no deficiencies cited during the follow-up to a Medicare recertification survey of your ASC conducted on 9/06/18 and 9/07/18 . The surveyors conducting the follow-up survey were: Teresa Hamblin, RN, MS, HFS Trish O'Hara, RN, CNN, HFS	{Q 000}		

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.