IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 11, 2019

Spencer Sessions, Administrator
Post Falls Ambulatory Surgical Center
602 North Calgary Court, Suite 203
Post Falls, ID 83854

RE: Post Falls Ambulatory Surgical Center, Provider #13C0001072

Dear Mr. Sessions:

On April 4, 2019, a follow-up visit of your facility, Post Falls Ambulatory Surgical Center, was conducted to verify corrections of deficiencies noted during the survey of February 11, 2019.

We were able to determine that the Conditions for Coverage of **Governing Body and Management (42 CFR 416.41), Quality Assessment And Performance Improvement (42 CFR 416.43), Laboratory And Radiologic Services (42 CFR 416.49), Patient Rights (42 CFR 416.50)** and **Infection Control (42 CFR 416.51)** 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/nw
Enclosures
ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001072	A. BUILDING _____ B. WING _____	R 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POST FALLS AMBULATORY SURGICAL CENTER	602 NORTH CALGARY COURT, SUITE 203 POST FALLS, ID 83854

(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 A Medicare follow up survey was conducted at your Ambulatory Surgical Center on 4/03/19 to 4/04/19. The agency was found to be in substantial compliance with §42 CFR 416. The surveyors conducting the survey were: James Brown, RN, HFS - Team Leader Trish O'Hara, RN, 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.