

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

Printed: 10/16/2008  
FORM APPROVED  
OMB NO. 0938-0391

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|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>SKSUCT</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>09/02/2008</b> |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><b>SKYLINE SURGERY CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>285 VISTA DRIVE. SUITE C<br/>POCATELLO, ID 83201</b> |
|---|--|

| (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 | <p><b>INITIAL COMMENTS</b></p> <p>The initial certification/deemed status survey for this ambulatory surgery center was completed by AAAHC and found to be in full compliance with all Medicare ambulatory surgery center Conditions for Coverage found under 42 CFR 416, effective September 2, 2008.</p> | 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.

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|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>SKYLINE SURGERY CENTER</b>         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>285 VISTA DRIVE. SUITE C<br/>POCATELLO, ID 83201</b> |   |   |
| (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                                |
| K 000   | <p><b>INITIAL COMMENTS</b></p> <p>The initial certification/deemed status survey for this ambulatory surgery center was completed by AAAHC and found to be in full compliance with all Medicare ambulatory surgery center Conditions for Coverage found under 42 CFR 416, effective September 2, 2008.</p> | K 000  |   |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |  | TITLE  |   | (X6) DATE   |

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