



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.L. "BUTCH" OTTER – 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 83720-0099
PHONE 208-334-6626
FAX 208-364-1888

July 20, 2011

Susan Pendlebury, Administrator
Snake River Dialysis Center
1491 Parkway Drive
Blackfoot, ID 83221

RE: Snake River Dialysis Center

Dear Ms. Pendlebury:

This is to advise you of the findings of the Medicare initial survey of Snake River Dialysis Center, which was conducted on July 14, 2011.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey. This form is for your records only and need not be returned.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Trish O'Hara". The signature is written in a cursive, slightly slanted style.

TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care

A handwritten signature in black ink that reads "Nicole Wisenor". The signature is written in a cursive, slightly slanted style.

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm
Enclosures

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

PRINTED: 07/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132524	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2011
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NAME OF PROVIDER OR SUPPLIER SNAKE RIVER DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1486 PARKWAY DRIVE BLACKFOOT, ID 83221
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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>INITIAL COMMENTS</p> <p>No deficiencies were cited during the initial Medicare certification survey of your dialysis unit. Snake River Dialysis Center is in compliance with the requirements of 42 CFR Part 405, Conditions for Coverage of End-Stage Renal Disease Facilities. The surveyor conducting the initial Medicare certification survey was:</p> <p>Patricia O'Hara RN, HFS</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.