



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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September 28, 2011

Troy Geyman, MD
Bonners Ferry Family Medicine
6488 Chinook Street
Bonners Ferry, Idaho 83805

RE: Bonners Ferry Family Medicine

Dear Dr. Geyman:

This is to advise you of the findings of the initial Medicare certification survey, which was concluded at your facility, Bonners Ferry Family Medicine, on September 28, 2011

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 GULES
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/srm

Enclosures

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

Printed: 10/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13XXXX	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2011
NAME OF PROVIDER OR SUPPLIER BONNERS FERRY FAMILY MEDICINE		STREET ADDRESS, CITY, STATE, ZIP CODE 6488 CHINOOK STREET BONNERS FERRY, ID 83805		
(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
J 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the initial Medicare certification survey of your Rural Health Clinic. Bonners Ferry Family Medical RHC is in compliance with the requirements of 42 CFR Part 491, Subpart A, Conditions for Certification of Rural Health Clinics. The surveyors conducting the initial Medicare certification survey were:</p> <p>Gary Guiles, R.N., H.F.S., Team Leader Susan Costa, R.N., H.F.S.</p>	J 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.