IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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November 30, 2018

Mark Heppler, Administrator
Gem State Regional Dialysis Center
2225 Teton Plaza
Idaho Falls, ID 83401

RE: Gem State Regional Dialysis Center, Provider #132500

Dear Mr. Heppler:

On November 28, 2018, a follow-up visit of your facility, Gem State Regional Dialysis Center, was conducted to verify corrections of deficiencies noted during the survey of October 19, 2018.

We were able to determine that the Conditions of Participation of **Patient Plan of Care (42 CFR 494.90), QAPI (42 CFR 494.110) and Responsibilities of the Medical Director (42 CFR 494.150)** 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,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt

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
	132500	A. BUILDING _____ B. WING _____	R 11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEM STATE REGIONAL DIALYSIS CENTER	2225 TETON PLAZA IDAHO FALLS, ID 83401

(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
{V 000}	INITIAL COMMENTS There were no deficiencies cited during the follow-up to a Medicare recertification survey of your dialysis facility conducted from 11/26/18 - 11/28/18. The surveyors conducting the follow-up survey were: Trish O'Hara, RN, CNN, HFS James Brown, RN, HFS	{V 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.