IDAHO DEPARTMENT OF HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

October 16, 2006

Amy Klingler
Salmon River Clinic
PO Box 129
Stanley, ID 83278

Dear Ms. Klingler:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Salmon River Clinic, on October 12, 2006.

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,

Penny Salow/sc

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosure

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

PRINTED: 10/13/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	133808		10/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALMON RIVER CLINIC	1 NIECE AVENUE STANLEY, ID 83278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	INITIAL COMMENTS No deficiencies were cited during the Medicare recertification survey of your Rural Health Clinic. Salmon River Clinic is in compliance with the requirements of 42 CFR 491, Subpart A, Conditions of Coverage of Rural Health Clinic services. The surveyor conducting the Medicare recertification survey was Penny Salow, R.N., H.F.S.	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.