IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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CERTIFIED MAIL: 7012 3050 0001 2125 5785

April 22, 2016

Ms. Terry Whybark, Administrator
Palouse Dialysis Center
723 South Main Street
Moscow, ID 83843

RE: Palouse Dialysis Center, Provider #132520

Dear Ms. Whybark:

Based on the survey completed at Palouse Dialysis Center, on April 15, 2016, by our staff, we have determined Palouse Dialysis Center is out of compliance with the Medicare ESRD Conditions for Coverage of **CFC-PATIENT PLAN OF CARE (42 CFR 494.90), CFC -QAPI (42 CFR 494.110) and CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR (42 CFR 494.150)**. To participate as a provider of services in the Medicare Program, an ESRD must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Palouse Dialysis Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before May 30, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than May 20, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **May 5, 2016**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Gary Keopanya, CMS Region X Office

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

PRINTED: 04/22/2016
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
	132520		04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOUSE DIALYSIS CENTER	723 SOUTH MAIN STREET MOSCOW, ID 83843

(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 CORE SURVEY The following deficiencies were cited during the recertification survey of your facility on 4/11 - 4/14/2016. The surveyors conducting the survey were: Trish O'Hara RN, HFS, Team Leader Nancy Bax RN, HFS Acronyms used in this report include: AMA - Against Medical Advice AVF - Arteriovenous Fistula BFR - Blood Flow Rate CVC - Central Venous Catheter DFR - Dialysate Flow Rate EDW - Estimated Dry Weight ICHD - Incenter Hemodialysis kg - kilogram Kt/V - Measure of dialysis adequacy min - minute ml - milliliter POC - Plan Of Care PT - Pharmaceutical Therapeutics QAI - Quality Assurance and Improvement QAPI - Quality Assurance Performance Improvement QSR - Quality Status Report URR - Urea Reduction Ratio, measure of dialysis adequacy	V 000	RECEIVED MAY - 5 2016 FACILITY STANDARDS	
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in	V 463		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Whyland | TITLE: RN/CM | (X6) DATE: 5-4-16

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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V 463	Continued From page 1 the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure each patient's right to receive care as outlined in their POCs was upheld for 3 of 3 ICHD patients (Patients #1, #3 and #4) whose treatment records were reviewed. This resulted in patients not receiving treatments as ordered with regard to Heparin administration, blood and dialysate flow rates, and time on the machine, which placed them at risk for complications and decreased adequacy. Additionally, vital signs were not monitored during treatment placing patients at risk for complications. Findings include: 1. Vital sign monitoring was not done during dialysis treatments as follows: A facility policy "Patient Monitoring During Patient Treatment," revised 8/20/14, stated "Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed. Observe for changes in the patient's respirations, heart rate and blood pressure. Verify and react to unusual findings such as atypical blood pressure readings." This policy was not followed. a. Patient #3 was a 63 year old male. Twelve treatment records, including 2 missed treatments, from 3/14/16 to 4/8/16, were reviewed. Four of the 10 records of treatments reviewed did not include documentation of vital signs every 30 minutes per policy as follows:	V 463		

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V 463	Continued From page 2 - On 3/14/16, no vital signs were recorded for 47 minutes, from 1:44 to 2:31 p.m., and for 60 minutes, from 2:31to 3:31 p.m. - On 3/21/16, no vital signs were recorded for 56 minutes, from 12:34 to 1:34 p.m., when his treatment was interrupted. No vital signs were recorded at the time his treatment was interrupted or when it was resumed at 2:15 p.m. No vital signs were recorded at 3:00 p.m., when Patient #3's treatment was interrupted a second time, or at 3:43 p.m., when it was resumed. Vital signs were recorded at 4:04 p.m. However, Patient #3's vital signs were not monitored for the 3 hours and 30 minutes, from 12:34 to 4:04 p.m. - On 4/4/16, no vital signs were recorded for 59 minutes, from 3:32 to 4:31 p.m. - On 4/6/16, no vital signs were recorded for 50 minutes, from 12:11to 1:01 p.m. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed the treatment records and confirmed vital signs were not recorded on treatment records according to facility policy. b. Patient #4 was a 20 year old female. Four treatment records, from 4/4/16 to 4/11/16, were reviewed, and 3 of 4 treatments did not include documentation of vital signs every 30 minutes. - On 4/4/16, Patient #4's first treatment at the facility, no vital signs were recorded for 60 minutes, between 1:03 to 2:03 p.m. No vital signs were recorded for 60 minutes between 2:31to 3:31 p.m. No vital signs were recorded for 66 minutes from 3:31 to 4:37 p.m., when treatment was discontinued.	V 463		

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V 463	Continued From page 3 - On 4/6/16, no vital signs were recorded for 51 minutes, from 12:40 to 1:31 p.m. - On 4/8/16, no vital signs were recorded for 66 minutes, from 2:30 to 3:36 p.m. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed the treatment records and confirmed vital signs were not recorded on treatment records according to facility policy. c. Patient #1 was a 48 year old female. Twelve treatment records, from 3/14/16 - 4/11/16, were reviewed, and 7 of 12 treatments did not include documentation of vital signs every 30 minutes. - On 3/16/16, no vital signs were recorded for 61 minutes, from 3:02 to 4:03 p.m. - On 3/21/16, no vital signs were recorded for 70 minutes from 1:32 p.m. to 2:42 p.m., and again for 46 minutes from 4:39 to 5:25 p.m. - On 3/25/16, no vital signs were recorded for 61 minutes from 3:00 to 4:01 p.m. - On 3/28/16, no vital signs were recorded for 65 minutes from 3:05 to 4:10 p.m. - On 4/4/16, no vital signs were recorded for 60 minutes from 3:32 to 4:32 p.m., and again for 60 minutes from 5:02 to 6:02 p.m. - On 4/6/16, no vital signs were recorded for 70 minutes from 4:03 to 5:13 p.m. - On 4/11/16, no vital signs were recorded for 55 minutes from the start of treatment at 2:39 to 3:34	V 463		

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V 463	Continued From page 4 p.m., and again for 60 minutes from 6:02 to 7:02 p.m. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed the treatment records and confirmed vital signs were not recorded on treatment records according to facility policy. Patients were not provided with vital sign monitoring according to policy. 2. Treatment times were not provided as prescribed on a patient's POC. A facility policy "Early Termination or Arriving Late for Treatment," revised 7/4/12, stated "If a patient requests to leave treatment early...the RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. The policy further stated "If the prescribed treatment time is not possible, the charge nurse/team leader will notify the physician that the patient will not receive their prescribed treatment and obtain additional orders if required. The facility staff should make every attempt to assist the patient with rescheduling any lost treatment time." This policy was not followed. a. Patient #3 was a 63 year old male. Twelve treatment records, from 3/14/16 to 4/8/16, were reviewed. Two of the 12 record documented missed treatments. His POC included treatment time of 4 hours. Five of 10 treatment times were shortened as follows: - 3/16/16: 66 minutes - 3/18/16: 8 minutes	V 463		

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V 463	Continued From page 5 - 3/21/16: 30 minutes - 3/28/16: 240 minutes (missed treatment) - 3/30/16: 240 minutes (missed treatment) - 4/1/16: 66 minutes - 4/4/16: 9 minutes Patient #3 missed a total of 10 hours and 59 minutes of his prescribed treatment time from 3/16/16 to 4/4/16. His treatment records did not include documentation stating his physician was notified of his 2 missed treatments or 5 shortened treatment times. Additionally, there was no documentation stating Patient #3 was offered the opportunity to reschedule lost treatment time. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #3's treatment records and confirmed the prescribed treatments were missed or shortened as documented above. She confirmed his physician was not notified, and stated she was not aware his physician should have been notified of missed or shortened treatments. Additionally, she confirmed Patient #3 was not offered the opportunity to make up his lost treatment time. Patient #3 was not provided treatment time as ordered and the facility failed to assist him to make up lost treatment time. 3. Heparin was not administered as ordered on patients' POCs. a. Patient #3 was a 63 year old male. Twelve	V 463		

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V 463	Continued From page 6 treatment records, including 2 missed treatments, from 3/14/16 to 4/08/16, were reviewed. Heparin was not administered as ordered during 9 of 10 treatments received. - 3/14/16: treatment time was 4 hours. Heparin was ordered to be given 1000 units per hour for a total of 4000 units. However, his treatment record stated total Heparin infused was 5000 units. - 3/16/16: treatment time was 1 hour and 54 minutes. Heparin was ordered to be given 1000 units per hour for a total of 1900 units. However, his treatment record stated total Heparin infused was 2900 units. - 3/18/16: treatment time was 3 hours and 32 minutes. Heparin was ordered to be given 1000 units per hour for a total of 3500 units. However, his treatment record stated total Heparin infused was 4800 units. - 3/21/16: treatment time was 3 hours and 30 minutes. Heparin was ordered to be given 1000 units per hour for a total of 3500 units. However, his treatment record stated total Heparin infused was 6900 units. - 3/23/16: treatment time was 4 hours. Heparin was ordered to be given 1000 units per hour for a total of 4000 units. However, his treatment record stated total Heparin infused was 7400 units. - 3/25/16: treatment time was 4 hours. Heparin was ordered to be given 1500 units per hour for a total of 6000 units. However, his treatment record stated total Heparin infused was 8200	V 463		

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V 463	Continued From page 7 units. - 4/1/16: treatment time was 2 hours and 44 minutes. Heparin was ordered to be given 1500 units per hour for a total of 4125 units. However, his treatment record stated total Heparin infused was 6400 units. - 4/6/16: treatment time was 4 hours. Heparin was ordered to be given 1500 units per hour for a total of 6000 units. However, his treatment record stated total Heparin infused was 2000 units. - 4/8/16: treatment time was 4 hours. Heparin was ordered to be given 1500 units per hour for a total of 6000 units. However, his treatment record stated total Heparin infused was 7900 units. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #3's treatment records and confirmed Heparin was not administered as ordered. b. Patient #4 was a 20 year old female. Four treatment records, from 4/4/16 to 4/11/16, were reviewed. Heparin was not administered as ordered during 2 of 4 treatments received. - 4/4/16: treatment time was 3.75 hours. Heparin was ordered to be given 500 units per hour for a total of 1875 units. However, her treatment record stated total Heparin infused was 2800 units. - 4/11/16: treatment time was 3.75 hours. Heparin was ordered to be given 500 units per hour for a total of 1875 units. However, her	V 463		

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V 463	Continued From page 8 treatment record stated total Heparin infused was 2800 units. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #4's treatment records and confirmed Heparin was not administered as ordered. c.Patient #1 was a 48 year old female. Twelve treatment records, from 3/14/16 to 4/11/16, were reviewed. Heparin was not administered as ordered during 9 of 12 treatments received. - 3/18/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 12,500 units. - 3/23/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,2500 units. However, her treatment sheet documented no Heparin had been given during the treatment. - 3/25/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 12,200 units. - 3/28/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 12,100 units - 3/30/16: treatment time was 4.75 hours. Heparin was ordered to be given at 2500 units	V 463		

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V 463	Continued From page 9 per hour for a total of 11,875 units. However, her treatment record documented total Heparin infused was 12,200 units. - 4/1/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 12,200 units. - 4/4/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 12,200 units. - 4/6/16: treatment time was 4.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 11,250 units. However, her treatment record documented total Heparin infused was 6500 units 4/11/16: treatment time was 5.5 hours. Heparin was ordered to be given at 2500 units per hour for a total of 13,750 units. However, her treatment record showed total Heparin infused was 13,200 units. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #1's treatment records and confirmed Heparin was not administered as ordered. Patients were not provided with Heparin as ordered. 4. Patients were not provided with BFRs as ordered in their POCs as follows:	V 463		

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V 463	Continued From page 10 a. Patient #3 was a 63 year old male. Twelve treatment records, including 2 missed treatments, from 3/14/16 to 4/08/16, were reviewed. Patient #3's POC included a BFR of 400 ml/minute. His prescribed BFR was not maintained for 8 of 10 treatments received as indicated by the following average BFRs: 3/14/16 - 220 ml/min average BFR 3/16/16 - 270 ml/min average BFR 3/18/16 - 230 ml/min average BFR 3/21/16 - 240 ml/min average BFR 3/23/16 - 280 ml/min average BFR 3/25/16 - 250 ml/min average BFR 4/1/16 - 260 ml/min average BFR 4/4/16 - 230 ml/min average BFR Patient #3's treatment records did not include documentation stating his physician was notified his prescribed BFR of 400 ml/min was not maintained as noted above. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #3's treatment records and confirmed he did not receive his prescribed BFR. She confirmed his physician was not notified, and stated she was not aware his physician should be notified when the prescribed BFR was not achieved. b.Patient #1 was a 48 year old female. Twelve treatment records, from 3/14/16 to 4/11/16, were	V 463		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	132520		04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOUSE DIALYSIS CENTER	723 SOUTH MAIN STREET MOSCOW, ID 83843

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V 463	Continued From page 11 reviewed. Patient #1's POC included a BFR of 400 ml/minute. Her prescribed BFR was not maintained for 10 of 12 treatments received as indicated by the following average BFRs: 3/14/16 - 260 ml/min average BFR 3/16/16 - 290 ml/min average BFR 3/18/16 - 380 ml/min average BFR 3/21/16 - 330 ml/min average BFR 3/23/16 - 360 ml/min average BFR 3/28/16 - 320 ml/min average BFR 3/30/16 - 330 ml/min average BFR 4/4/16 - 320 ml/min average BFR 4/6/16 - 290 ml/min average BFR 4/11/16 - 290 ml/min average BFR During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #1's treatment records and confirmed she did not receive her prescribed BFR. She confirmed her physician was not notified, and stated she was not aware her physician should have been notified when the prescribed BFR was not achieved. Patients were not provided with prescribed BFRs. 5. Patients were not provided with DFRs as ordered in their POCs, as follows: Patient #4 was a 20 year old female. Four	V 463		

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V 463	Continued From page 12 treatment records, from 4/4/16 to 4/11/16, were reviewed. Patient #4's POC included a DFR of 800 ml/minute. However, her treatment record dated 4/4/16, stated her average DFR was 600 ml/minute. During an interview on 4/13/16 at 10:00 a.m., the Clinic Nurse reviewed Patient #4's treatment records and confirmed her DFR on 4/4/16 was not provided at 600 ml/minute as ordered. Patient #4 was not provided with her prescribed DFR. The facility failed to ensure patients were provided with dialysis treatments as prescribed.	V 463		
V 518	494.80(c) PA-ASSESS HD ADEQ Q MO;PD ADEQ Q 4 MO The adequacy of the patient's dialysis prescription, as described in §494.90(a)(1), must be assessed on an ongoing basis as follows: (1) Hemodialysis patients. At least monthly by calculating delivered Kt/V or an equivalent measure. (2) Peritoneal dialysis patients. At least every 4 months by calculating delivered weekly Kt/V or an equivalent measure. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the adequacy of hemodialysis patients' dialysis prescriptions was assessed at least monthly for 1	V 518		

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V 518	Continued From page 13 of 3 ICHD patients (Patient #3) whose records were reviewed. This failure resulted in patients being put at risk of not receiving adequate hemodialysis. Findings include: Patient #3 was a 63 year old male. Twelve treatment records from 3/14/16 to 4/08/16, were reviewed. Laboratory reports from January to March 2016 were reviewed. Patient #3's record included results for blood tests collected on 1/18/16, 2/19/16, and 3/21/16. The tests collected on 1/18/16 and 2/19/16, included results of URR and Kt/V tests, used to determine hemodialysis treatment adequacy. However, the tests collected on 3/21/16 did not include URR or Kt/V results. As of 4/13/16, no blood test to measure hemodialysis treatment adequacy was performed after 2/19/16. During an interview on 4/13/16 at 10:20 a.m., the Clinic Nurse reviewed Patient #3's record and confirmed his most recent test to determine hemodialysis treatment adequacy was performed on 2/19/16. The facility failed to assess Patient #3's hemodialysis treatment adequacy on a monthly basis.	V 518		
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on staff interview, review of clinical records, and review of policy and procedure, it was determined the facility failed to recognize and meet individual patient needs. The cumulative	V 540		

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V 540	Continued From page 14 effects of these failures resulted in patients' individual needs not being addressed and patients not receiving care as ordered by their physicians. Findings include: 1. Refer to V463 as it relates to the facility's failure to uphold the patients' rights to receive care as prescribed in their plans of care. 2. Refer to V518 as it relates to the facility's failure to ensure a patient's hemodialysis adequacy was monitored on a monthly basis. 3. Refer to V543 as it relates to the facility's failure to ensure patients' POCs were implemented by addressing volume status. 4. Refer to V544 as it relates to the facility's failure to ensure a patient attained adequate hemodialysis. The cumulative effect of these systemic failures impeded the ability of the facility to provide services of sufficient scope and quality.	V 540		
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a POC was implemented by addressing volume status for 1of 3 ICHD patients (Patient #3) whose records were reviewed. This failure resulted in a	V 543		

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V 543	Continued From page 15 patient being put at risk of complications resulting from fluid overload or dehydration. Findings include: Patient #3 was a 63 year old male. Twelve treatment records, including 2 missed treatments, from 3/14/16 to 4/08/16, were reviewed. Pre-dialysis weights, volume of fluid removed (an automatic download from the machine to the treatment sheet), and post dialysis weights were compared to his prescribed EDW. Patient #3's EDW was 84.5 kg. Post dialysis weights were above his EDW for 5 of 10 treatments received. Examples include: - Patient #3's pre-dialysis weight on 3/14/16, was 88.6 kg. During treatment 4604 ml of fluid was removed and 600 ml of fluid was given. Patient #3's post dialysis weight was 85.2 kg, 0.7 kg over his EDW. - Patient #3's pre-dialysis weight on 3/16/16, was 88.5 kg. During treatment 2136 ml of fluid was removed and no fluid was given. Patient #3's post dialysis weight was 87.0 kg, 2.5 kg over his EDW. - Patient #3's pre-dialysis weight on 3/18/16, was 88.1 kg. During treatment 3188 ml of fluid was removed and no fluid was given. Patient #3's post dialysis weight was 85.7 kg, 1.2 kg over his EDW. - Patient #3's pre-dialysis weight on 3/21/16, was 88.1 kg. During treatment 3401 ml of fluid was removed and no fluid was given. Patient #3's post dialysis weight was 86.1 kg, 1.6 kg over his EDW.	V 543		

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V 543	Continued From page 16 - Patient #3's pre-dialysis weight on 4/4/16, was 87.3 kg. During treatment 2951 ml of fluid was removed and no fluid was given. Patient #3's post dialysis weight was 86.2 kg, 0.7 kg over his EDW. During an interview on 4/13/16 at 10:20 a.m., the Clinic Nurse reviewed Patient #3's record and confirmed he did not reach his EDW on 5 of 10 treatments received. The facility failed to ensure Patient #3's volume status was managed appropriately.	V 543		
V 544	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure a patient's POC was adjusted to allow for the achievement and maintenance of adequate hemodialysis for 1 of 3 ICHD patients (Patient #1) whose records were reviewed. This failure put the patient at risk of complications from excess systemic waste build up. Findings include: KDOQI Clinical Practice Guidelines for Hemodialysis Adequacy, 2006, recommend a minimum dialysis adequacy of 65% URR. A 2015 update to these recommendations did not change	V 544		

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V 544	Continued From page 17 the URR minimum value from 65%. Patient #1 was a 48 year old female who had been admitted to the facility on 9/9/2015 using a CVC for dialysis treatments. Laboratory blood results were reviewed for January - March 2016. Her adequacy was measured using URR methodology. On 1/18/16 Patient #1's URR was measured at 53%. On 2/15/16 URR was measured at 61%. On 3/21/16 URR was measured at 52%. In an interview on 4/13/16 at 9:30 a.m., the Clinic Nurse confirmed the low adequacy measures. She said the low adequacy was due to a poorly functioning CVC. The nurse said staff had been trying to hold off on replacing the CVC because they were waiting for Patient #1's AVF to mature enough to be used for dialysis. In an interview on 4/13/16 at 8:30 a.m., the Clinic Manager said a request had been made, to the corporate PT committee, for approval for a larger dialyzer for Patient #1 to increase her adequacy. As of the survey date, the request had not been approved. The facility failed to ensure Patient #1 was provided with adequate dialysis.	V 544		
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Based on staff interview and review of QAI meeting minutes, it was determined the facility failed to ensure an effective QAPI program was	V 625		

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V 625	Continued From page 18 maintained that collected data, and recognized and corrected problems affecting patients' health. This failure had the potential to decrease the quality of treatment received by patients. Findings include: 1. Refer to V634 as it relates to the lack of data collection for treatment prescription errors.	V 625		
V 634	494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on staff interview and review of QAI documents, it was determined the facility failed to ensure the QAI program collected, monitored and analyzed patient data related to treatment prescription errors for 3 of 3 ICHD patients (Patients #1, #3 and #4) whose records were reviewed. This limited the facility's ability to develop and implement plans that would result in improvements in patient care. Findings include: 1. Hemodialysis QSR reports for 12/2015 - 2/2016 were reviewed. These reports showed the QAI committee did not track patient data related to prescribed BFRs not being attained as follows: - Patient #1 did not attain her prescribed BFR during 10 of 12 treatments reviewed. - Patient #3 did not attain his prescribed BFR	V 634		

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V 634	Continued From page 19 during 8 of 10 treatments reviewed. In an interview on 4/13/16 at 8:30 a.m., the Clinic Manager said data related to unmet patient BFRs was not collected or reported to the QAI committee. 2. Hemodialysis QSR reports for 12/2015 - 2/2016 were reviewed. These reports showed the QAI committee did not track patient data related to prescribed Heparin doses as follows: - Patient #1 did not receive her prescribed Heparin dose during 9 of 12 treatments reviewed. - Patient #3 did not receive his prescribed Heparin dose during 9 of 10 treatments reviewed. - Patient #4 did not receive her prescribed Heparin dose during 2 of 4 treatments reviewed. In an interview on 4/13/16 at 8:30 a.m., the Clinic Manager said data related to incorrect patient Heparin dosing was not collected or reported to the QAI committee. 3. Hemodialysis QSR reports for 12/2015 - 2/2016 were reviewed. These reports showed the QAI committee did not track patient data related to monitoring during treatment as follows: A facility policy "Patient Monitoring During Patient Treatment," revised 8/20/14, stated "Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed. Observe for changes in the patient's respirations, heart rate and blood pressure. Verify and react to unusual findings such as atypical blood pressure readings."	V 634		

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V 634	Continued From page 20 - Patient #1 did not receive monitoring according to policy during 7 of 12 treatments reviewed. - Patient #3 did not receive monitoring according to policy during 4 of 10 treatments reviewed. - Patient #4 did not receive monitoring according to policy during 3 of 4 treatments reviewed. In an interview on 4/13/16 at 8:30 a.m., the Clinic Manager said data related to lack of patient monitoring during treatment was not collected or reported to the QAI committee. 4. Hemodialysis QSR reports for 12/2015 - 2/2016 were reviewed. These reports showed the QAI committee did not track patient data related to shortened treatment times as follows: - Patient #3 did not receive his prescribed dialysis time during 5 of 10 treatments reviewed. A policy titled Early Termination or Arriving Late for Treatment, revised 7/4/12, stated AMA forms were "Tracked, trended and reported to the QAI committee monthly." In an interview on 4/13/16 at 8:30 a.m., the Clinic Manager said data related to shortened treatment times was not collected or reported to the QAI committee. The facility failed to ensure all patient outcomes were included in the QAI program.	V 634		
V 710	494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR	V 710		

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V 710	Continued From page 21 This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure the Medical Director provided oversight needed to ensure the delivery of quality patient care and to ensure the operation of an effective QAPI program. This failure created the potential for negative patient outcome for all patients dialyzing at the facility. Findings include: 1. Refer to V540:Condition for Coverage Patient Plan of Care and the associated standard level deficiency as it relates to the Medical Director's failure to ensure patients' dialysis treatments were delivered as prescribed. 2. Refer to V625:Condition for Coverage QAPI, and associated standard level deficiencies as they relate to the Medical Director's failure to ensure the operation of an effective QAPI program.	V 710		
V 756	494.180(a)(4) GOV-ADM RESP FOR RESOURCES FOR QAPI The governing body or designated person responsible must appoint an individual who serves as the dialysis facility's chief executive officer or administrator who exercises responsibility for the management of the facility and the provision of all dialysis services, including, but not limited to- (4) Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program as described in §494.110.	V 756		

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V 756	Continued From page 22 This STANDARD is not met as evidenced by: Based on staff interview and QAI meeting minutes review, it was determined the facility failed to provide adequate staff and resources necessary for QAI data collection. This failure had the potential to impact the health outcomes of all patients dialyzing at the facility. Findings include: Review of QAI meeting minutes from 12/2015 - 2/16 showed there was no submission of patient chart audit results. When asked in an interview on 4/13/16 at 4:00 p.m., the Clinic Manager said she was responsible for auditing patient records. She said these audits had several objectives including verification that patients were receiving treatments as prescribed by their physicians. However, she said, due to being short staffed at the facility, she had been providing direct patient care and had not had the time to perform patient chart audits for several months. She confirmed there was no documentation of chart audits in the QAI meeting minutes. The facility failed to ensure the provision of staff time to compile comprehensive data for the QAI committee.	V 756		

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MAY - 5 2016
FACILITY STANDARDS

Fresenius Medical Care

Dba Palouse Dialysis, Moscow, ID

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: April 15, 2016

V 463

On 04/29/2016, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- Patient Monitoring During Patient Treatment
- Initiation of Treatment Using an Arteriovenous Graft or Fistula and Optiflux Single Use Ebeam Dialyzer
- Termination of Treatment Using Arteriovenous Fistula or Graft and Optiflux Single Use Ebeam Dialyzer
- Pre-Treatment Safety Checks
- Early Termination or Arriving Late for Treatment
- Patient Non-Adherence to Schedule
- Heparinization
- Use of the Heparin Pump

Emphasis was placed on:

- Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed.
- If patient requests to leave treatment early the RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. If the prescribed treatment time is not possible, the charge nurse /team leader will notify the physician that the patient will not receive their prescribed treatment and obtain additional orders if required. The facility staff will make every attempt to assist the patient with rescheduling any lost treatment time.
- A bolus loading dose is administered 3-5 minutes pretreatment with a second bolus dose administered mid treatment.
- Check machine settings and measurements and document at the initiation of dialysis and at every safety check. Blood flow rate: Check prescribed blood flow is being achieved. Make adjustments as needed. Dialysate flow rate: Check setting is correct and the prescribed flow is being delivered. Unusual observations, findings and the inability to reach prescribed orders must be promptly reported to the charge nurse/team leader. Notify the physician as determined by the clinical judgment of the charge nurse/team leader.

Effective immediately, Clinical Manager or designee for a period of two weeks will daily monitor 50% of patient treatment sheets for variances >30min checks, shortened treatments, Heparin monitoring, BFR and DFR rate adherence. Adherence to the policy will result in the frequency reduced to 25% 3X weekly for two additional weeks and then 25% once a week for two weeks using daily audit tool. Once compliance sustained monitoring will be done through the medical record audit per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on 5/11/16.

V518

On 4/29/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- Comprehensive Interdisciplinary Assessment and Plan of Care
- Measurement of Delivered Dose of Hemodialysis

Emphasis was placed on:

- All patients will have pre/post BUN drawn monthly, any patient that has a missed lab will be rescheduled for the next treatment day.
- Physician will be notified of missed lab and rescheduled date.

Effective immediately,

Clinical Manager or designee will verify every month that every patient has a kt/v/URR result by running a lab ordered status report weekly. Any patient missing kt/v or URR will be rescheduled for next treatment. Compliance will be monitored through monthly lab order review reports.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on 5/11/16.

V540

The Governing Body acknowledges its responsibility to ensure Fresenius Medical Care Palouse Dialysis meets the needs of the patients by ensuring patients' individual needs addressed and patients receive care as ordered by their physician.

The interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, includes measurable and expected outcomes and estimated timetables to achieve these outcomes and encourages the patient's participation in developing and updating the plan of care.

The Governing Body, on 4/28/16, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body began meeting weekly beginning 5/6/16 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule.

Effective Immediately:

1. The Clinical Manager will analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.

2. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.

3. The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.

4. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

5. The Governing Body, at its meeting of 4/28/16, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and

the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.

The responses provided for V463, V518, V543, V544 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance.

The deficiency was corrected on 5/11/16.

V543

On 4/29/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- Initiation of Treatment Using an Arteriovenous Graft or Fistula and Optiflux Single Use Ebeam Dialyzer
- Termination of Treatment Using Arteriovenous Fistula or Graft and Optiflux Single Use Ebeam Dialyzer
- Nursing Supervision and Delegation

Emphasis was placed on:

- Ensuring a plan of care was implemented by addressing volume status to reduce risk for fluid overload or dehydration.

Effective immediately,

Clinical Manager or designee for a period of two weeks will weekly monitor 50% of patient treatment sheets for variances > 0.5kg's. Adherence to the policy will result in the frequency reduced to 25% 2x weekly for two additional weeks and then 10% once a week for two weeks. Once compliance sustained monitoring will be done through the medical record audit per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on 5/11/16.

V544

On 4/29/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- Comprehensive Interdisciplinary Assessment and Plan of Care

Emphasis was placed on:

- All patients' kt/v result will be reviewed weekly. Any patient that is not meeting the kt/v goal of 1.4 will be further investigated and discussed with the physician.
- ICHD Adequacy tool will be implemented for any patient not meeting adequacy to assess for root causes.

Effective immediately,

Clinical Manager or designee will review patient lab results weekly and consult the physician for order to increase BFR, increase DFR, increase dialyzer, or increase time as indicated. Compliance will be monitored through monthly lab order review reports.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on 5/11/16.

V625

The Governing Body of Palouse Dialysis acknowledges its responsibility to ensure process in place to collect data and review for treatment adjustments.

The interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, includes measurable and expected outcomes and estimated timetables to achieve these outcomes and encourages the patient's participation in developing and updating the plan of care.

The Governing Body, on 4/29/16, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body began meeting weekly beginning 5/6/16 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule.

Effective Immediately:

1. The Clinical Manager will analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.

2. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.

3. The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.

4. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

5. The Governing Body, at its meeting of 4/29/16, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.

The responses provided for V634 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance.

The deficiency was corrected on 5/11/16.

V634

On 4/29/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- Initiation of Treatment Using an Arteriovenous Graft or Fistula and Optiflux Single Use Ebeam Dialyzer
- Termination of Treatment Using Arteriovenous Fistula or Graft and Optiflux Single Use Ebeam Dialyzer
- Patient Monitoring During Patient Treatment
- Nursing Supervision and Delegation

- Pre-Treatment Safety Checks

Emphasis was placed on:

- Ensuring a plan of care was implemented by addressing blood flow rate being delivered and adequate documentation is in place for any patient not able to meet prescribed blood flow as ordered by physician.

Effective immediately,

Clinical Manager or designee for a period of two weeks will weekly monitor 50% of patient treatment sheets for variances in blood flow rate that do not meet physician order, heparin delivered as prescribed, Vital Signs every 30 minutes, and prescribed length of dialysis. Adherence to the policy will result in the frequency reduced to 25% 2x weekly for two additional weeks and then 10% once a week for two weeks. Once compliance sustained monitoring will be done through the medical record audit per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on 5/11/16.

V710

The Medical Director acknowledges his responsibility to:

- Ensure responsibility for the staff performance and compliance, patient rights, patient assessment, patient plan of care, and governance
- Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program

- Be actively involved in the oversight and implementation of the facility's policies and procedures for the infection control program, physical environment, patient rights, patient assessment, patient plans of care, personnel qualifications, and medical records
- Evaluate data collected for revision of improvement plan as necessary until resolution

The Governing Body, on 4/29/2016, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body began meeting weekly beginning 5/6/2016 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule.

Effective Immediately:

1. The Clinical Manager will analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.

2. A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.

3. The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.

4. The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

5. The Governing Body, at its meeting on 4/29/16, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and

the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.

The responses provided for V540 and V625 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance.

The deficiency was corrected on 5/11/16.

V756

On 4/28/16, the Director of Operations held a meeting with Medical Director to review the Statement of deficiencies and reinforced the expectations and responsibilities of the Medical Director and Governing body on below stated responsibilities:

- Maintain oversight and monitoring of the QAPI program which ensures safe, effective delivery of patient care and outcomes and failure to identify systems to improve patient care and decrease adverse patient outcomes.
- Compilation of comprehensive data for the QAPI program to review and analyze.
- Allocation of necessary staff and other resources for the facility's quality assessment and performance improvement program

By 5/6/16, Clinical Manager or designee will have audited 10% of Medical records and have data for Governing Body and QAI to review. The QAPI Committee, will ensure the immediate and ongoing identification of potential and actual problems to patient care and take appropriate steps to identify the root causes and to develop, implement and track corrective actions through to resolution.

Effective immediately, Director of Operations will review staffing and ensure facility has adequate staff for Clinical Manager to perform her duties as discussed above.

Any issues/problems will be addressed within the QAPI via steps as noted throughout the POC, documented in the QAPI minutes, and formally reported to the Governing Body. Minutes of the Governing Body and QAPI meetings, as well as, monitoring forms, educational documentation will provide evidence of these actions, the GB's direction and oversight and the QAPI Committees ongoing monitoring of the facility's activities. These are available at the facility for review.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The deficiency was corrected on 5/11/16.

Jerry Whytlark 5-11-16

Matt Senk 5-11-16