IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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August 1, 2016

Dana Camacho, Administrator
Treasure Valley Dialysis Center
3045 E St Lukes St 105
Meridian, ID 83642

RE: Treasure Valley Dialysis Center, Provider #132513

Dear Ms. Camacho:

Based on the survey completed at Treasure Valley Dialysis Center, on July 21, 2016, by our staff, we have determined Treasure Valley Dialysis Center is out of compliance with the Medicare ESRD Conditions for Coverage of **CFC-Patients-Rights (42 CFR 494.70), CFC-Patient Plan of Care (42 CFR 494.90) and CFC-Governance (42 CFR 494.180)**. 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 Treasure Valley 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 September 4, 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 August 22, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **August 15, 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.

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,

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
CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132513	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3045 E ST LUKES ST 105 MERIDIAN, ID 83642

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your facility conducted from 7/18/16 - 7/21/16. The surveyor conducting the survey was: Trish O'Hara RN, HFS Acronyms used in this report: AFA - Assistant Facility Administrator BKA - Below the Knee Amputation CFH - Certified Family Home c/o - complains of CSS - Clinical Services Specialist CVA - Cerebral Vascular Accident (stroke) DFR Dialysate Flow Rate FA - Facility Administrator GFA - Group Facility Administrator ICHD - Incenter Hemodialysis IDPN - Intradialytic Parenteral Nutrition IDT - Interdisciplinary Team Kg - kilogram (2.2 pounds) ml/min - milliliter per minute MSW - Masters Social Worker NP - Nurse Practitioner QA - Quality Assurance RN - Registered Nurse TW - Target Weight UF - Ultrafiltration (fluid removal)	V 000		
V 450	494.70 CFC-PATIENTS- RIGHTS This CONDITION is not met as evidenced by: Based on staff and patient interviews, review of clinical records, and review of policy and	V 450	V450 Members of the Governing Body (GB) of Treasure Valley Dialysis have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Conditions of Patient Rights (V450), including standard V452 that are not met contain specifics of corrective plans. The Governing Body will meet weekly to ensure compliance with the POC. Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC.	8/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Facility Administrator 8/12/16

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 450	Continued From page 1 procedure, it was determined the facility failed to recognize and meet individual patient needs. This failure resulted in the violation of patients' rights to have their individual needs addressed and to be treated with dignity. Findings include: 1. Refer to V452 as it relates to the facility's failure to uphold patients' rights to dignity and respect and to have their individual needs addressed.	V 450		
V 452	494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that patients were treated with dignity and received individualized care. This failure directly impacted 6 of 6 ICHD patients (Patients #1 - #6) whose treatment sheets were reviewed and had the potential to impact all patients receiving care at the facility. This resulted in non-ambulatory patients not receiving toileting assistance, a patient not having physical and psychosocial complaints addressed, and patients experiencing extensive wait times for treatment. The findings include: 1. A patient was not provided with assistance to the restroom. Patient #1 was a 57 year old male who had been	V 452	100% of clinical teammates were in-serviced on 1) ""Eyes of the Customer,"" PowerPoint presentation on patient rights, 2) Policy 3-01-06A Addressing Patient Grievances: DaVita Teammates, 3) PowerPoint presentation Culture of Safety which included a section on transferring patients from wheelchair to chair, 4) reviewed Policy 1-05-17 "Care of Patients who are Incontinent of Bowel While on Dialysis," 5) reviewed PowerPoint presentation FluidWise management, 6) reviewed PowerPoint presentation on using correct and complete documentation including assessments, care plans, and homeroom meeting which will incorporate plans of how to address patient needs while on dialysis and Documentation of successful completion of the Transfer Skills checklist has been completed for 100% of all clinical. Beginning week of August 8th 2016, the FA will complete the patient questionnaire section from Comprehensive Audit Tool (CAT) with each patient. Documentation of this review will be placed in each patient's medical record. Completion of questionnaire by 8/26/2016. V452 cont on page 3	8/20/16

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V 452	Continued From page 2 dialyzing at the facility since 4/5/16. He had a history of recent CVA and right BKA. Patient #1 was wheelchair dependent and required assistance with his clothing during toileting. He lived in a CFH 25 miles from the dialysis facility. Eleven treatment sheets, from 6/21/16 - 7/16/16, were reviewed. A treatment sheet, dated 7/7/16, documented at 3:44 p.m., Patient #1 "was incontinent and was unable to be changed at this time. Unable to leave floor with other patients on machines. He was offered time to make up. He refused to make up time loss. His driver was called and he picked him up with in 20 minutes." A second note on the treatment sheet, at 3:44 p.m., stated "Patient was incontinent of stool at this time. Patient was unable to be taken to the bathroom due to staff ratio to patient ratio this would be unsafe. Patient was offered time to make up other day[sic] No other auxiliary staff available at this hour." Both notes were signed by the RN. Additionally, an e-mail written by the AFA, dated 7/8/16, quoted a staff as saying "the patient asked to come off to go to the restroom" but the charge nurse told her "they weren't going to take the patient off to use the restroom, he could come off and go home because she did not think it was safe to take him to the restroom." The charge nurse stated, in the same e-mail "i [sic] felt this was not a safe thing to leave other patients on the machines and have the last two staff members in the building both help patient in the bathroom." In an interview on 7/20/16 at 12:30 p.m., Patient #1 said he was capable of transferring himself from his wheelchair to the toilet but could not pull	V 452	V452 Continued from page 2 The FA or designee will review the grievance procedure with all patients, documentation of this review will be placed in the patient's medical record. . The FA will review the teammate/patient schedule and make adjustments as needed to ensure appropriate time is allowed to provide for patient care including assisting patients with toileting needs. Notification to patients of any schedule changes will be made 8/12/16. The revised schedule will be implemented by 9/5/16 and will be based on staffing model and the acuity guideline. The FA or designee will complete a review of 25% of daily flow sheets for 2 weeks, then weekly for 4 weeks. Teammates failing to follow policy and procedure related to addressing patient issues and/or notification of the appropriate teammate of patient issues will be counseled. Continued failure will result in disciplinary action. Ongoing compliance will be monitored through a 10% review of flow sheets monthly. The FA will review the grievance log as part of the homeroom/Core team meeting biweekly. Grievances will be addressed in accordance with the timeline defined in the grievance policy. The FA will review audit results and grievance log monthly as part of the QAPI/Facility health Meeting with Medical Director. The FA will implement changes to the plan of correction as necessary. The Facility Administrator is responsible for the implementation, monitoring and sustainability of this plan.	8/20/16

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V 452	Continued From page 3 his trousers up or down. He had asked for assistance to the restroom during his treatment on 7/7/16 and was told by staff they did not have time to help him. He also said he had been refused assistance two other times, although he could not recall the exact dates. He said he was not incontinent at home but had started wearing disposable undergarments to dialysis because of the lack of assistance he had experienced. In a phone interview on 7/20/16 at 9:00 a.m., Patient #1's caregiver said he had called the dialysis unit the morning of 7/7/16 on behalf of Patient #1. He told staff Patient #1 had been experiencing diarrhea during the night and asked if the patient should come to dialysis. He was told it was not the facility's policy to take patients to the restroom during treatment, but the patient should come to dialysis where he would be assessed. Patient #1 came to the facility where he was assessed, by the nurse and the nurse practitioner, as stable and appropriate to proceed with dialysis. Treatment was started at 12:23 p.m. The caregiver stated after Patient #1's treatment was ended early on 7/7/16 at 3:44 p.m., he was pushed into the lobby area, in a soiled condition, and waited 45 minutes for his ride to arrive for his 25 mile trip home. The caregiver called the facility's corporate office concerning the occurrence and was told the issue needed to be handled at the facility level. He then filed a grievance at the facility. In an interview on 7/21/16 at 3:30 p.m., the AFA said Individual #1 should have been assisted to the restroom on 7/7/16, thus avoiding the episode of incontinence and shortened treatment time. A policy titled Care Of Patients Who Are	V 452		

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V 452	Continued From page 4 Incontinent Of Bowel While On Dialysis, dated March, 2010, stated "The facility must be equipped to clean patients if they should have an episode of bowel incontinence...The facility will have a plan on how to best provide privacy in their facility when it is necessary to clean and care for the patient." Patient #1 was not treated with dignity and individualized care relative to toileting needs. 2. A patient did not have physical and psychosocial complaints addressed. During initial assessments for treatments, Patient #1 expressed complaints, documented in pre treatment assessments, as follows: - 6/25/16 "c/o 'choking' recently." -6/28/16 "States feels 'blah' no interest in anything." - 7/2/16 "c/o constipation, c/o loss of energy, depressed." - 7/5/16 "c/o constipation." - 7/9/16 complained of late treatment start time. - 7/12/16 "c/o loss of appetite, c/o constipation." - 7/14/16 "c/o loss of appetite, losing weight." - 7/16/16 "c/o nausea; c/o loss of appetite." The physician increased Patient #1's DFR from 600 ml/min to 800 ml/min on 7/2/16. In an interview on 7/21/16 at 3:30 p.m., the AFA said Patient #1's DFR increase on 7/5/16 was done to increase clearance and hopefully increase the patient's appetite. No additional documentation was found addressing Patient #1's constipation, loss of	V 452		

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V 452	Continued From page 5 appetite, weight loss, depression, or late start times. In an interview on 7/21/16, the facility's social worker said she had administered a depression questionnaire to Patient #1, with normal results, on 6/2/16 and was not aware the patient was currently experiencing depressive symptoms. Patient #1's EDW was decreased from 106.5 kg to 104.5 kg on 6/28/16, from 104.5 kg to 104 kg on 6/30/16, and from 104 kg to 100 kg on 7/14/16. However, there was no documentation indicating the cause of the 6.5 kg (14.3 pound) weight loss, over a 24 day period, had been investigated or treated. Patient #1's individual needs were not recognized or addressed. 3. Six patients experienced delayed treatment times. All patients were provided with printed patient rights and responsibilities at the time of admission. Included in patient responsibilities was a requirement stating "You are to come for treatment/appt as scheduled and to arrive on time." In an interview on 7/21/16 at 3:30 p.m., the AFA said a patient's assigned treatment time was considered to be the time a patient's dialysis treatment actually started on the dialysis machine clock. She said patients were required to arrive at the facility 15 - 20 minutes prior to their assigned treatment time. Six patients' treatment sheets were reviewed	V 452		

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V 452	Continued From page 6 from 6/20/16 - 7/16/16, focusing on treatment start times. Patients' treatment start times were delayed, by more than 10 minutes, an average of 40.5% of treatments reviewed. Including the required early arrival time, patients waited at least 30 minutes for their treatments to begin. Individual results were as follows: - Patient #1 was assigned a treatment start time at 12:00 p.m. His actual start time was later than 12:10 p.m. during 83% of treatments reviewed. - Patient #2 was assigned a treatment start time at 11:40 a.m. Her actual start time was later than 11:50 a.m. during 75% of treatments reviewed. - Patient #3 was assigned a treatment start time at 6:40 a.m. Her actual start time was later than 6:50 a.m. during 25% of treatments reviewed. - Patient #4 was assigned a treatment start time at 12:20 p.m. Her actual start time was later than 12:30 p.m. during 22% of treatments reviewed. - Patient #5 was assigned a treatment start time at 6:20 a.m. His actual start time was later than 6:30 a.m. during 8% of treatments reviewed. - Patient #6 was assigned a treatment start time at 10:15 a.m. Her actual start time was later than 10:25 a.m. during 30% of treatments reviewed. Of the 27 treatment sheets showing late start times, only 1 treatment sheet explained why the treatment was delayed. There was no documentation showing any of the delayed treatments were caused by late arrival by patients.	V 452		

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V 452	Continued From page 7 In an interview on 7/20/16 at 5:00 p.m., the CSS said scheduling for each group of treatment stations allowed for no more than one event to occur every 20 minutes, and 45 minutes were allowed for each chair between patients. In an interview on 7/21/16 at 3:30 p.m., the AFA said treatments were occasionally delayed because of complications with an earlier patient in the same chair. Patients' rights were not observed and patients were not treated with respect relative to extensive wait times.	V 452		
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on staff and patient interview and clinical record review, it was determined the facility failed to ensure POCs were based on comprehensive assessments and failed to ensure POCs were implemented. This resulted in patients' individualized needs not being met by staff. The findings include: 1. Refer to V541 as it relates to the facility's failure to develop patient POCs based on assessed needs. 2. Refer to V543 as it relates to the facility's failure to manage patients' volume status.	V 540	V540 Members of the Governing Body (GB) of Treasure Valley Dialysis have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Conditions of Patient Plan of Care (V540), including standard V541, and V543 that are not met contain specifics of corrective plans. The Governing Body will meet weekly to ensure compliance with the POC. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi- annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC.	8/20/16
V 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80	V 541		

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V 541	Continued From page 8 must 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, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the POC addressed all of the assessed needs for 3 of 3 patients (Patients #1, #2, and #6) who had ambulatory disabilities. Failure to address these needs resulted in a lack of information being available to facility staff regarding patient interventions. The findings include: 1. Patient #1 was a 57 year old male who had been dialyzing at the facility since 4/5/16. He had a history of recent CVA and right BKA. Patient #1 was wheelchair dependent. His nursing assessment included an area titled Health Maintenance & Safety. Individualized information including mobility deficits, toileting needs, and amputation, had been collected for Patient #1. While he was adequately assessed, the individualized information was not carried over to his POC, dated 5/5/16. No plans were developed or implemented addressing Patient #1's mobility deficit due to CVA, need for toileting assistance, and BKA.	V 541	V541 The Clinical Services Specialist (CSS) in-serviced 100% of the clinical teammates on 08/04/2016 on policy 1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis." Training included but was not limited to ensuring assessment findings with regards to patient disabilities or special needs to be addressed in the POC and effectively communicated to the direct patient care teammates. Evidence of training was accomplished using a training sign in sheet. Homerooms will be conducted daily starting 8/8/2016 the charge nurse will be implementing a new homeroom structure to focus on patient needs and interventions found on the POC. The FA will audit weekly 100% of homeroom logs weekly for completion. Going forward, the FA or designee will review care plans completed following a nursing assessment to ensure that assessment findings are referenced in plans of care as needed. Teammates failing to properly address issues identified as part of the assessment will be counseled. The FA will review the Homeroom logs and the results of the care plan audits during monthly QAPI/ FHM meeting with Medical Director. The FA will implement changes to the plan of correction as necessary. The Facility Administrator is responsible for the implementation, monitoring and sustainability of this plan.	8/20/16

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V 541	Continued From page 9 The template used for Patient #1's POC also had a category titled Health Maintenance/Safety. However, the information on the POC was limited only to Patient #1's fall risk. The goal was stated as "Maintain Total Fall Risk Assessment Score of <=5." Patient #1's POC indicated this goal had been met because "Patient has not had a fall here at the clinic. Will continue to have fall precautions in place." There was no additional information present in the POC on which to base a plan addressing Patient #1's individualized needs for toileting assistance or assistance with mobility. 2. Patient #2 was a 65 year old female who had initiated hemodialysis at the facility on 7/23/15. She used an electric cart for mobility and was unable to ambulate unassisted. Her nursing assessment included an area titled Health Maintenance & Safety. Individualized information including mobility deficits and toileting needs had been collected for Patient #2. While she was adequately assessed, the individualized information was not carried over to her POC, dated 8/25/15. No plans were developed or implemented addressing Patient #2's mobility deficit, assistance with ambulation, or toileting assistance. The template used for Patient #2's POC also had a category titled Health Maintenance/Safety. However, the information on the POC was limited only to the patient's fall risk. The goal was stated as "Maintain Total Fall Risk Assessment Score of <=5."	V 541		

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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
V 541	Continued From page 10 There was no additional information present on the POC on which to base a plan addressing Patient #2's individualized need for assistance with toileting or ambulation. 3. Patient #6 was a 69 year old female who had been dialyzing at the facility since 1/6/10. She was wheelchair dependent, due to progressive muscle weakness, and required the assistance of two people for transfers. Her nursing assessment included an area titled Health Maintenance & Safety. Individualized information including mobility deficits and toileting needs had been collected for Patient #6. Although the patient was adequately assessed, the individualized information was not carried over to her POC, dated 10/7/15. No plans were developed or implemented addressing Patient #6's mobility deficit or need for assistance with transfers or toileting. The template used for Patient #6's POC also had a category titled Health Maintenance/Safety. However, the information on the POC was limited only to the patient's fall risk. The goal was stated as "Maintain Total Fall Risk Assessment Score of <=5." There was no additional information present on the POC on which to base a plan addressing Patient #6's individualized need for assistance with mobility, transfers or toileting. In an interview on 7/21/16 at 3:30 p.m., the AFA and GFA confirmed individualized assessed needs were not addressed on the POCs for Patients #1, #2, and #6.	V 541		

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	132513	A. BUILDING _____ B. WING _____	07/21/2016

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V 541	Continued From page 11 Patients' assessed needs were not addressed in their POCs.	V 541		
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 volume status was accurately tracked and reported for 3 of 6 ICHD patients (Patients #1, #2,and #6) whose treatment sheets were reviewed. This failure resulted in patients leaving the facility at risk of complications from fluid overload or dehydration. The findings include: 1. Patient #1 was a 57 year old male who had dialyzed at the facility since 4/5/16. Twelve treatment sheets were reviewed from 6/2/161 - 7/16/16 with the following results: - On 6/21/16 pre weight was 105.1 kg and post weight was 104.9 kg, a loss of 0.2 kg. The machine recorded 1.0 kg had been removed. Additionally, Patient #1 left the facility 1.6 kg below his TW. - On 6/23/16 his pre weight was 105.1 kg and post weight was 103.6 kg, a loss of 1.5 kg. The machine recorded 1.0 kg had been removed. Additionally, Patient #1 left the facility 2.9 kg below his TW. - On 6/25/16 his pre weight was 105.2 kg and	V 543	V543 The CSS in-serviced 100% of clinical teammates on 08/04/2016 on FluidWise management, communication on the floor, and FluidWise focus reporting. Evidence of training was accomplished using a training sign in sheet. Surveyor observations were also shared with the team to include: facility failed to ensure volume status was accurately tracked and reported for 3 of 6 ICHD patients. The Clinical nurse manager (CNM) and Register Dietitian (RD) will complete a review of all patients current ordered Target Weight (TW). The CNM and RD will provide the physician with a list of TW that require review for potential TW order change. The CNM or designee will complete a 25% daily flow sheet audit X 2 weeks, then weekly X 4 weeks - focusing on target weight and falcon intervention from the IDT team. Teammates failing to follow policy and procedure will be counseled. TW issues will be flagged for the physician to address weekly. FA will review results of the TW review process and the flow sheets audits during monthly QAPI/FHM with Medical Director. The FA will implement changes to the plan of correction as necessary. The Facility Administrator is responsible for the implementation, monitoring and sustainability of this plan.	8/20/16

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V 543	Continued From page 12 post weight was 103.6 kg, a loss of 1.6 kg. The machine recorded 2.5 kg had been removed. Additionally, Patient #1 left the facility 2.9 kg below his TW. - On 6/28/16 pre weight was 104.8 kg and post weight was 104.3 kg, a loss of 0.5 kg. The machine showed 1.5 kg had been removed. - On 6/30/16 pre weight was 104.1 kg and post weight was documented as 104 kg, a loss of 0.1 kg. The machine showed 1.3 kg had been removed. - On 7/2/16 pre weight was 105.4 kg and post weight was 104.4 kg, a loss of 1.0 kg. while the machine showed 1.9 kg had been removed. - On 7/5/16 pre weight was 104.3 kg and post weight was 103.2 kg, a loss of 1.1 kg. The machine recorded 1.9 kg had been removed. - On 7/7/16 pre weight and post weight were both documented as 102.3 kg while the machine recorded 1.3 kg had been removed. Additionally, Patient #1 left the facility 3 kg below his TW. - On 7/9/16 pre weight was 101.8 kg and post weight was 102.1 kg, a gain of .3 kg. The machine recorded 1.0 kg had been removed. Additionally, Patient #1 left the facility 1.9 kg below his TW. - On 7/12/16 Patient #1 left the facility 2.5 kg below his TW. The treatment sheets reviewed had no documentation showing extra fluid had been given to Patient #1 orally or by IV. There was no	V 543		

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V 543	Continued From page 13 documentation the physician or extender was notified when Patient #1's post weight was more than 1 kg below his TW. 2. Patient #6 was a 67 year old female who had dialyzed at the facility since 1/6/10. Nine treatment sheets were reviewed from 6/21/16 - 7/16/16 with the following results: - On 6/28/16 her post weight was 1.7 kg above her TW. - On 7/2/16 her post weight was 2.4 kg above her TW. - On 7/7/16 her post weight was 3.5 kg above her TW. - On 7/9/16 pre weight was 61.7 kg and post weight was 61 kg, a .7 kg loss, while the machine recorded 2.5 kg had been removed. Additionally, her post weight was 4.0 kg above her TW. - On 7/12/16 her post weight was 2.8 kg above her TW. - On 7/14/16 pre weight was 62.9 kg and post weight was 59 kg, a 3.9 kg loss, while the machine recorded 2 kg had been removed. Additionally, her post weight was 2 kg above her TW. The treatment sheets reviewed had no documentation showing extra fluid had been given to Patient #6 orally or by IV. No documentation was present showing Patient #6 was offered extra dialysis time four of the six	V 543		

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V 543	Continued From page 14 times she was more than 1 kg above her TW. There was no documentation the physician or extender was alerted when Patient #6's post weight was more than 1 kg above her TW. 3. Patient #2 was a 65 year old female who had been dialyzing at the facility since 7/23/15. Eleven treatment sheets were reviewed from 6/21/16 - 7/16/16 with the following results: - On 6/21/16 her post weight was 2.2 kg above her TW. - On 6/23/16 her post weight was 4.5 kg above her TW. - On 6/25/16 pre weight was 52.6 kg and post weight was 52.3 kg, a loss of 0.3 kg, while the machine recorded 2.0 kg had been removed. Additionally, Patient #2 left the facility 4.8 kg above her TW. - On 6/28/16 pre weight was 54 kg and post weight was 51.9 kg, a 2.9 kg loss, while the machine recorded 3.8 kg had been removed. Additionally, Patient #2 left the facility 3.6 kg above her TW with noted peripheral and facial edema. The treatment sheets reviewed included a doctor's order for .5 kg IDPN each treatment, and an order to add .5 kg in Patient #2's UF goal to balance the fluid input. No documentation was present showing Patient #2 was offered extra dialysis time for fluid removal when she was more than 1 kg above her TW. There was no documentation the physician or extender was alerted when Patient #2's post	V 543		

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V 543	Continued From page 15 weight was more than 1 kg above her TW. In an interview on 7/20/16 at 5:00 p.m., the CSS said it was facility protocol to alert the physician or his/her extender if a patient's post dialysis weight was +/- 1.0 kg from their TW and to offer extra dialysis time for fluid removal. In an interview on 7/21/16 at 3:30 p.m., the AFA confirmed the weight loss discrepancies. The facility failed to ensure fluid status was managed.	V 543		
V 750	494.180 CFC-GOVERNANCE This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure the Governing Body exercised responsibility for the facility's operation. This failure resulted in lack of quality patient care demonstrated by patients' rights violations, inadequate patient POCs, and lack of patient grievance resolution. The findings include: 1. Refer to V751 as it relates to the facility's failure to ensure patients' rights were protected. 2. Refer to V765 as it relates to the facility's failure to ensure the internal grievance process was implemented per policy.	V 750	V750 Members of the Governing Body (GB) of Treasure Valley Dialysis have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Condition of Governance (V750), including standard V751, and V765 that are not met contain specifics of corrective plans. The Governing Body will meet weekly to ensure compliance with the POC. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi-annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC.	8/20/16
V 751	494.180 GOV-ID GOV BODY W/FULL AUTHORITY/RESPONS The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and	V 751		

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V 751	Continued From page 16 responsibility for the governance and operation of the facility. The governing body adopts and enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients ' personal and property rights, and to the general operation of the facility. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the Governing Body failed to ensure policies were sufficiently monitored to protect patients' rights for 6 of 6 ICHD patients (Patients #1 - #6) whose records were reviewed, resulting in the lack of quality patient care. The findings include: 1. The Governing Body consisted of the Medical Director, the Group Facility Administrator, and the Facility Administrator. A review of personnel files for all staff at the facility showed documentation of annual training on clinical skills, infection control, emergency procedures, water, dialysate, and machines. No information was present showing annual staff training related to patient rights, respect and dignity. In a phone interview on 7/29/16 at 9:30 a.m., the CSS stated staff were trained on patients' rights, respect, and dignity at the time of orientation. However, there was no further training required of, or provided to, staff related to patients' rights, respect and dignity. The Governing Body failed to ensure staff members were adequately trained and demonstrated the competencies necessary to	V 751	V751 100% of Governing Body (GB) were in-serviced by the CSS on roles and responsibilities of governing body of the facility, oversight of the facility, and day to day operations. The GB reviewed the statement of deficiencies and surveyor observations which include: the Governing Body failed to ensure policies were sufficiently monitored to protect patient. This process will by audited by the CSS during monthly FHM meeting for the next 4 months. The GB will meet weekly until the condition level citations have been lifted to review the statement of deficiencies, the plan or correction with focus on follow through and that any identified needed changes to the plan of correction are implemented, monitored and sustained to prevent future issues. 100% of teammates will be trained on policy 3-01-07 Patient Rights and Responsibilities and 3-01-07A Patient Rights and Responsibilities Facilities Rules by 8/20/16. The FA will review the teammate/patient schedule and make adjustments as needed to ensure appropriate time is allowed to provide for patient care including assisting patients with toileting needs. Notification to patients of any schedule changes will be made 8/12/16. The revised schedule will be implemented by 9/5/16 and will be based on staffing model and the acuity guideline. Going forward this will be added to the annual mandatory training for teammates. FA will review the statement of deficiencies and plan of correction during monthly QAPI/FHM until plans are complete and sustainability can be determined with Medical Director. The FA will implement changes to the plan of correction as V751 cont on page 17	8/20/16

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V 751	Continued From page 17 meet patients' needs, uphold patients' rights and treat patients with dignity and respect. 2. Refer to V450 CfC: Patient Rights and the associated standard level deficiencies as they relate to the Governing Body's failure to ensure Patient Rights were upheld. 3. Refer to V540 CfC: Plan of Care and the associated standard level deficiencies as they relate to the Governing Body's failure to ensure patients' POCs were developed and implemented.	V 751	V751 Continued from page 17 necessary. The Facility Administrator is responsible for the implementation, monitoring and sustainability of this plan.	8/20/16
V 765	494.180(e) GOV-INTERNAL GRIEVANCE SYS ID/IMPLEMENTED The facility's internal grievance process must be implemented so that the patient may file an oral or written grievance with the facility without reprisal or denial of services. The grievance process must include- (1) A clearly explained procedure for the submission of grievances. (2) Timeframes for reviewing the grievance. (3) A description of how the patient or the patient's designated representative will be informed of steps taken to resolve the grievance. This STANDARD is not met as evidenced by: Based on staff interview and review of patient grievances, it was determined the facility failed to ensure grievances were addressed and resolved for 1 of 1 patients (Patient #1) for whom a grievance had been filed during the past three months. This prevented the facility from utilizing grievances to improve care. Findings include:	V 765	V765 The CSS in-serviced 100% of clinical team on grievance policy 3-01-06A "Addressing Patient Grievances: DaVita Teammates.", on 8/1 and 8/4/16. The FA or designee will review the grievance procedure with all patients, documentation of this review will be placed in the patient's medical record. Grievances will be addressed in accordance with the timeline defined in the grievance policy. The FA will review the grievance log as part of the homeroom/Core team meeting biweekly. The FA will review the grievance log monthly as part of the QAPI/Facility health Meeting with Medical Director. The FA will implement changes to the plan of correction as necessary. The Facility Administrator is responsible for the implementation, monitoring and sustainability of this plan.	8/20/16

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V 765	Continued From page 18 Patient #1 was a 57 year old male who had been dialyzing at the facility since 4/5/16. He had a history of recent CVA and right BKA. Patient #1 was wheelchair dependent and required assistance with his clothing during toileting. He lived in a CFH 25 miles from the dialysis facility. A treatment sheet, dated 7/7/16, documented at 3:44 p.m., Patient #1 "was incontinent and was unable to be changed at this time. Unable to leave floor with other patients on machines. He was offered time to make up. He refused to make up time loss. His driver was called and he picked him up with in 20 minutes." A second note on the treatment sheet, at 3:44 p.m., stated "Patient was incontinent of stool at this time. Patient was unable to be taken to the bathroom due to staff ratio to patient ratio this would be unsafe. Patient was offered time to make up other day[sic] No other auxiliary staff available at this hour." Both notes were signed by the RN. In an interview on 7/20/16 at 12:30 p.m., Patient #1 said he was capable of transferring himself from his wheelchair to the toilet but could not pull his trousers up or down. He had asked for assistance to the restroom during his treatment on 7/7/16 and was told by staff they did not have time to help him. He also said he had been refused assistance two other times, although he could not recall the exact dates. He said he was not incontinent at home but had started wearing disposable undergarments to dialysis because of the lack of assistance he had experienced. In a phone interview on 7/20/16 at 9:00 a.m.,	V 765		

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V 765	Continued From page 19 Patient #1's caregiver said he had called the dialysis unit the morning of 7/7/16 on behalf of Patient #1. He told staff Patient #1 had been experiencing diarrhea during the night and asked if the patient should come to dialysis. He was told the patient should come to dialysis where he would be assessed. The caregiver was also told it was not the facility's policy to take patients to the restroom during treatment. Patient #1 was brought to the facility where he was assessed, by the nurse and the nurse practitioner, as stable and appropriate to proceed with dialysis. Treatment was started at 12:23 p.m. The caregiver said after Patient #1's treatment was ended early on 7/7/16 at 3:44 p.m., he was pushed into the lobby area, in a soiled condition, and waited 45 minutes for his ride to arrive for his 25 mile trip home. The caregiver called the facility's corporate office concerning the occurrence and was told the issue needed to be handled at the facility level. He then filed a grievance at the facility. The grievance, dated 7/8/16 10:00 a.m., concerning the occurrence on 7/7/16, was reviewed. The section titled IDT and Complainant Resolution stated "NP and floor RN evaluated patient and OK'd him for treatment to start. When patient was in continent [sic] during treatment, treatment was discontinued and he was sent home per his request. Make up treatment time was offered to patient. Team coaching planned for team meeting in July." It was unclear who had completed the form. The section asking 'Is the Patient Satisfied with Resolution?' was left blank. There were no signatures in the spaces marked Patient, FA, MSW, or Medical Director.	V 765		

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V 765	Continued From page 20 In an interview on 7/21/16 at 12:30 p.m., the patient said no one from the facility had come to talk to him, to offer an apology, resolution, or reassurance the situation would not occur again. In an interview on 7/21/16 at 3:30 p.m., the AFA said the facility was "still in process" with the grievance. She confirmed no staff or administration had talked to the patient. An e-mail from the AFA to the FA, GFA and QA officer, dated 7/8/16, was attached to the grievance report. It stated three staff had been interviewed. A policy titled Addressing Patient Grievances: DaVita Teammates, revised March, 2013, stated "The charge nurse will discuss the grievance with the patient and take appropriate action toward a solution, if possible...If the patient grievance cannot be resolved by the charge nurse, the FA will be notified. The FA will discuss the grievance with the patient and take appropriate action towards a solution, if possible. This discussion should occur within 10 days of receipt of the grievance." By close of business on 7/21/16, fourteen days after the grievance was filed, there had been no discussion with the patient and no corrective action had been taken by the facility. The facility failed to ensure its grievance policy was implemented.	V 765		