IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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Boise, Idaho 83720-0009
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*****Corrected Letter*****

November 10, 2016

Cecilia Rincon-Cervantes, Administrator
Idaho Kidney Center Pocatello
444 Hospital Way, Suite 600
Pocatello, ID 83201

RE: Idaho Kidney Center Pocatello, Provider #132511

Dear Ms. Rincon-Cervantes:

Based on the survey completed at Idaho Kidney Center Pocatello, on October 31, 2016, by our staff, we have determined Idaho Kidney Center Pocatello is out of compliance with the Medicare ESRD Conditions for Coverage of **CFC-Patient Plan of Care (42 CFR 494.90), CFC- Quality Assurance Performance Improvement (42 CFR 494.110), CFC- Responsibilities of the Medical Director (42 CFR 494.150) 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 Idaho Kidney Center Pocatello, 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 Conditions 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 December 12, 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 November 23, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 23, 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,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/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
	132511	A. BUILDING _____ B. WING _____	10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO KIDNEY CENTER POCATELLO	444 HOSPITAL WAY, SUITE 600 POCATELLO, ID 83201

(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 from 10/24/16 - 10/31/16. The surveyors conducting the survey were: Trish O'Hara, RN, Team Leader Laura Thompson, RN Acronyms used in this report include: AMA - Against Medical Advice BP and bp - Blood Pressure c/o - complaints or complains of DW - Dry Weight EDW - Estimated Dry Weight ER - Emergency Room g - gauge HHD - Home Hemodialysis HTN - Hypertension ICHD - Incenter Hemodialysis Kg - Kilogram (2.2 pounds) LUA - Left Upper Arm MD - Medical Doctor mg - milligram min - minute ml - milliliter NS - Normal Saline O2 - Oxygen PCT - Patient Care Technician PD - Peritoneal Dialysis PRN - As needed pt - patient QAPI - Quality Assurance Performance Improvement RN - Registered Nurse	V 000		

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

DIRECTOR OF OPERATIONS | 11/17/16

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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	132511	A. BUILDING _____ B. WING _____	10/28/2016

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 10/24/16 - 10/28/16. The surveyors conducting the survey were: Trish O'Hara, RN, Team Leader Laura Thompson, RN Acronyms used in this report include: AMA - Against Medical Advice BP and bp - Blood Pressure c/o - complaints or complains of DW - Dry Weight EDW - Estimated Dry Weight ER - Emergency Room g - gauge HHD - Home Hemodialysis HTN - Hypertension ICHD - Incenter Hemodialysis Kg - Kilogram (2.2 pounds) LUA - Left Upper Arm MD - Medical Doctor mg - milligram min - minute ml - milliliter NS - Normal Saline O2 - Oxygen PCT - Patient Care Technician PD - Peritoneal Dialysis PRN - As needed pt - patient QAPI - Quality Assurance Performance Improvement RN - Registered Nurse	V 000	RECEIVED NOV 18 2016 FACILITY STANDARDS	

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Director of Operations 11/17/16

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V 000	Continued From page 1 SBP - Systolic Blood Pressure UF - Ultrafiltration (fluid removal) Note: Immediate Jeopardy was identified at V543 and the facility was notified on 10/28/16 at 11:30 a.m. The facility submitted a Plan of Correction and the Immediate Jeopardy was removed on 10/28/16 at 1:45 p.m.	V 000		
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. This resulted in patients not receiving individualized care and being put at risk for negative dialysis treatment outcomes. The findings include: 1. Refer to V543 as it relates to the facility's failure to consistently identify and address patients' hypotension and hypertension, and to adequately monitor patients' vital signs during treatments.	V 540		11/29/16
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 policy review, record review, and staff interview it was determined the facility failed to identify acceptable upper and lower blood	V 543		11/29/16

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V 543	Continued From page 2 pressure parameters and expected interventions, allowing episodes of intradialytic hypertension and hypotension to be inconsistently identified, addressed, and monitored for 4 of 6 ICHD patients (Patients #5, #7, #8 and #10) whose treatment records were reviewed. These failures allowed the potential for patients to experience serious harm, impairment or death related to broad variances in blood pressure and lack of monitoring during treatments. The findings include: A policy titled Determination of Blood Pressure, revised 7/4/12, instructed staff to "Set the blood pressure high and low parameter alarm limits on the dialysis machines to alert the clinician to changes in the patient's clinical condition...The Medical Director in conjunction with the Clinical Manager will determine what blood pressure upper and lower range parameters will be for the facility." The policy stated "The following conditions can lead to serious outcomes and even death: Untreated/unattended severe hypertension (>200 systolic), Untreated/unattended severe hypotension (<80 systolic), Blood pressures not rechecked to verify correctness of the result when a major drop or increase occurs." A procedure titled Determination of Blood Pressure, revised 9/23/13, stated "The settings should be the following, unless otherwise ordered by the attending physician: Systolic high 180, low 100. Diastolic high 100, low 50." A document titled Idaho Kidney Center - Pocatello Initial Physicians Orders for Hemodialysis, not dated, documented "Clonidine 0.1 mg PRN	V 543		

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V 543	Continued From page 3 hypertension, MD to be notified prior to administration for BP Systolic >200 and to specify medication and dose." Further, a policy titled 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." The facility's policies were not implemented, as follows: 1. Patient #10 was a 24 year old female who had dialyzed at the facility since 11/2/12. Eleven treatment sheets were reviewed, from 9/26/16 - 10/24/16. The treatment records documented Patient #10's blood pressure was not consistently monitored and her hypertensive episodes were not consistently identified and addressed, placing her at risk of serious harm, impairment or death, as follows: - 9/26/16: Patient #10 was noted to be hypertensive in a pre treatment nursing assessment with a BP reading of 199/119, and in a post treatment nursing assessment with a BP reading of 179/105. Patient #10's UF was turned off after 35 minutes of treatment, with no documented explanation and a BP reading of 184/95. The UF remained off until the end of treatment. She ended treatment 3 kg above her EDW. Patient #10 missed treatments on 9/28/16 and 9/30/16 due to a hospitalization for hypertension. - 10/3/16: Patient #10 was identified in pre treatment nursing assessment as hypertensive	V 543		

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V 543	Continued From page 4 with a BP reading of 256/116, with no intervention noted, and in a post treatment nursing assessment with a BP reading of 153/93. - 10/5/16: Patient #10 was identified in a pre treatment nursing assessment as hypertensive with a BP reading of 204/118. No BP reading was recorded for the first 70 minutes of treatment, at which time a PCT note documented her BP was 225/113. A post treatment nursing assessment documented a BP reading of 202/109. No interventions were noted. - 10/7/16: No BP reading was recorded for 54 minutes, from 5:05 p.m. - 5:59 p.m. - 10/10/16: Patient #10 was identified as hypertensive in a pre treatment nursing assessment with a BP reading of 236/115, and in a post treatment nursing assessment with a BP reading of 186/102. No interventions were noted and she ended treatment 4 kg above her EDW. - 10/14/16: Patient #10 was identified as hypertensive in a pre treatment nursing assessment with a BP reading of 231/153. Dialysis was initiated at 3:15 p.m. when her BP reading was 238/151. BP was documented as 206/119 at 3:32 p.m. No BP reading was recorded for the next 64 minutes when, at 4:37 p.m., her BP was documented as 176/95. At 5:34 p.m. Patient #10's BP was 181/97. Three minutes later, at 5:37 p.m. Patient #10's record documented "UF off; pt. c/o chest pain, RN notified." No vital signs or other interventions were taken at that time. RN assessment of Patient #10's chest pain could not be found, and an explanation of why her UF had been turned off	V 543		

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V 543	Continued From page 5 was not present. A post treatment nursing assessment noted a BP reading of 192/110 and said Patient #10 was "councelled [sic] to cut fluid intake by 1/2." No other interventions were noted and she ended treatment 3 kg above her EDW. - 10/17/16: Patient #10 was identified as hypertensive in a pre treatment nursing assessment with a BP reading of 213/119. No BP reading was recorded for 99 minutes, from 3:26 p.m., when her BP was 237/142, until 5:05 p.m. A post treatment nursing assessment documented a BP reading of 191/96. No interventions were noted. - 10/19/16: Patient #10 was identified as hypertensive in pre treatment nursing notes with a BP reading of 203/110, and in post treatment notes with a BP reading of 193/94. No interventions were noted. - 10/21/16: Patient #10's pre treatment BP reading was 219/116. A pre treatment nursing assessment stated "Arrives saying she is feeling aweful [sic] with a headache and nausea related to hypertension. Says she was in the hospital and received a shot for her BP." Patient #10 remained hypertensive throughout her treatment, according to PCT notes, and had "continued hypertension" recorded in a post treatment nursing assessment with a BP reading of 193/117. No interventions were noted. - 10/24/16: Patient #10 was identified as hypertensive in a pre treatment nursing assessment with a BP reading of 224/125. Her treatment started at 3:17 p.m. Hypertension	V 543		

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V 543	Continued From page 6 continued throughout her 3 hour and 15 minute treatment, according to RN and PCT notes, with BP readings of 227/128 at 4:01 p.m., 217/122 at 5:08 p.m., 226/106 at 5:32 p.m., and 213/124 at 6:03 p.m. Clonidine 0.3 mg was administered at 6:05 p.m., after 168 minutes of identified hypertension and 27 minutes before the end of treatment. A post treatment nursing note stated "Pt. left facility via ambulance at pt. request to go to the ER. She was having severe anxiety. HTN remains with Clonidine on board." Patient #10 was hospitalized from 9/28/16 - 9/30/16, reported hospital intervention on 10/21/16, and was transported to the hospital on 10/24/16 due to her hypertension. However, the facility did not ensure her blood pressure was consistently monitored and that her hypertensive episodes were consistently addressed. In an interview on 10/26/16 at 2:00 p.m., one staff nurse stated he was not aware of specific blood pressure parameters or specific nursing intervention directives for facility patients. He said he was familiar with his patients and knew what to expect, relative to their blood pressure, during treatment. When asked specifically about Patient #10 he said "she always runs high because she doesn't take her blood pressure medicine at home." In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager confirmed patient vital sign monitoring was not consistent with the facility policy. The Clinical Manager said she and the Medical Director had not discussed or set specific blood pressure parameters for the facility and she did not know what parameters staff used.	V 543		

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V 543	Continued From page 7 The facility failed to ensure Patient #10 received safe and appropriate care based on her individualized needs. 2. Patient #7 was a 27 year old male who had been dialyzing at the facility since 11/16/15. Twelve treatment sheets were reviewed, from 9/26/16 - 10/24/06. The treatment records documented Patient #7's blood pressure was not consistently monitored and his hypertensive episodes were not consistently identified and addressed, placing him at risk of serious harm, impairment or death, as follows: - 9/26/16: Patient #7 was identified in nursing notes as hypertensive with a pre dialysis BP reading of 184/100 and a post dialysis BP reading of 182/102. No interventions were noted. - 9/29/16: No BP readings were recorded for 59 minutes, from 11:07 a.m. - 12:06 p.m. - 9/30/16: Patient #7 was identified in nursing notes as hypertensive with a pre dialysis BP reading of 171/95 and a post dialysis BP reading of 194/103. No interventions were noted. He ended treatment 1.5 kg above his EDW. - 10/5/16: No BP readings were recorded for 68 minutes, from 11:00 a.m. - 12:08 p.m. Patient #7 was identified in nursing notes as hypertensive with a post treatment BP reading of 185/95. No interventions were noted. - 10/7/16: Patient #7 was identified in nursing notes as hypertensive with BP readings of 183/84 at 1:37 p.m., 219/105 at 2:35 p.m., and a post treatment reading of 222/108. No interventions were noted.	V 543		

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V 543	Continued From page 8 - 10/10/16: Patient #7 was identified in nursing notes as hypertensive with a pre dialysis BP reading of 176/100, during treatment with a reading of 201/114 at 11:07 a.m., and a post treatment reading of 184/84. No interventions were noted. He ended treatment 1.5 kg above his EDW. - 10/14/16: Patient #7 was identified in nursing notes as hypertensive with a pre dialysis BP reading of 186/105. The RN documented "continued hypertension" when Patient #7 had a post treatment BP reading of 144/74. - 10/17/16: No BP readings were recorded for 67 minutes, from 1:00 p.m. - 2:07 p.m. Patient #7's nursing note stated "HTN noted" with a post treatment BP reading of 160/82. - 10/19/16: Patient #7's nursing note stated "HTN noted" with a pre dialysis BP reading of 173/92. No BP readings were recorded for 1 hour 55 minutes, from 12:34 p.m. - 2:29 p.m., the end of treatment. - 10/21/16: Patient #7 was identified in a pre treatment nursing assessment as hypertensive with a BP reading of 185/86, during treatment, in a PCT note with a BP reading of 228/102 at 2:06 p.m., and again in a post treatment nursing assessment with a BP reading of 205/104. No interventions were documented and he ended treatment 2 kg above his EDW. - 10/24/16: Patient #7 was identified in pre dialysis nursing notes as hypertensive with a BP reading of 146/79, and again in post treatment nursing notes with a BP reading of 141/72.	V 543		

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V 543	Continued From page 9 In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager confirmed patient vital sign monitoring was not consistent with the facility policy. The Clinical Manager said she and the Medical Director had not discussed or set specific blood pressure parameters for the facility and she did not know what parameters staff used. The facility failed to ensure Patient #7's blood pressure was consistently monitored and that his hypertensive episodes were consistently identified and addressed based on his individualized needs. 3. Patient #8 was a 93 year old male who had dialyzed at the facility since 2/9/15. Thirteen treatment sheets were reviewed from 9/26/16 - 10/24/16. The treatment records documented Patient #8's blood pressure was not consistently monitored and his hypotensive episodes were not consistently identified and addressed, placing him at risk of serious harm, impairment or death, as follows: - 9/26/16: Patient #8 was identified in nursing notes as hypotensive at 1:37 p.m. with a BP reading of 90/39. There was no intervention until 2:41 p.m. when Patient #8's BP reading was 78/40 and the UF was turned off. - 10/3/16: Patient #8 was identified in a pre treatment nursing assessment as hypertensive with a sitting BP reading of 129/89. The record did not include documentation regarding why the RN had identified Patient #8 as hypertensive given a SBP of 129. - 10/5/16: Patient #8 was identified in a pre	V 543		

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V 543	Continued From page 10 treatment nursing assessment as hypertensive with a BP reading of 148/99. The record did not include documentation regarding why the RN had identified Patient #8 as hypertensive given a SBP of 148. The record also documented Patient #8 presented 3 kg above his EDW and his UF goal was set for 2 kg. He ended treatment 1.5 kg above his EDW. - 10/7/16: Patient #8 presented with a pre dialysis BP reading of 114/63. At 1:45 p.m. he was noted to be hypotensive with a BP reading of 80/52 and the UF was turned off for the remaining 2 hours and 15 minutes of his treatment. No BP was recorded for 67 minutes, from 2:05 p.m. - 3:12 p.m. at which time Patient #8 was identified in a PCT note as hypotensive with a BP reading of 90/60. His post treatment BP reading was documented as 216/124 with an RN note stating "continued hypertension." There was no documentation Patient #8's BP was retaken to confirm accuracy. Patient #8 ended treatment 2.5 kg above his EDW (identical to his pre treatment weight) with an RN note stating "left center above DW due to excessive fluid gain." Patient #8's hypotension was not mentioned. - 10/10/16: Patient #8 was not identified as hypotensive with a post treatment BP reading of 90/44. He was discharged "in stable condition." - 10/12/16: A PCT note showed patient #8's BP was 98/40 at 1:36 p.m., and said BP would be rechecked in 15 minutes. However, his BP was not rechecked for 30 minutes at which time the reading was 92/55. His BP was not rechecked again for 24 minutes. - 10/17/16: Patient #8's UF was turned off after 2	V 543		

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V 543	Continued From page 11 hours and 7 minutes of treatment. Documentation showed he had no complaints and his BP reading was 106/56. The UF remained off throughout the remaining 1 hour and 48 minutes of treatment. He ended treatment 1 kg above his EDW. An RN note stated "left above DW due to excessive fluid gain." No mention was made regarding why the UF had been turned off. - 10/19/16: A PCT note showed Patient #8's BP was 94/47 at 11:30 a.m., and said his BP would be rechecked in 15 minutes. His BP was not rechecked for 32 minutes at which time it was recorded as 100/52. His BP was not checked again for 59 minutes, when it was recorded as 97/62. - 10/21/16: A PCT note showed Patient #8's BP was 82/40 at 12:35 p.m., and said his BP would be rechecked in 15 minutes. His BP was not rechecked for 30 minutes, at 1:05 p.m. At that time BP was 91/58. Again, the PCT note said BP would be rechecked in 15 minutes. A BP was not rechecked for 30 minutes, at 1:35 p.m. Additionally, no BP was recorded for 50 minutes, from 2:00 p.m. - 2:50 p.m. On the same date, Patient #8's PCT notes twice stated he was bradycardic (having a slow heartbeat, usually less than 60/min,) with pulse rates of 118/min and 120/min recorded. On the same date, a PCT note at 3:34 p.m. stated Patient #8's BP had dropped, while no BP was recorded on the treatment sheet, and said he continued to be bradycardic, while no pulse rate was recorded on the treatment sheet.	V 543		

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V 543	Continued From page 12 - 10/24/16: A PCT note showed Patient #8's BP was 96/51 at 2:35 p.m., and his BP would be rechecked in 15 minutes. His BP was not rechecked for 30 minutes. One PCT, in an interview on 10/28/16 at 8:20 a.m., said she did not believe there was a policy for blood pressure parameters but more of a nurse's directive. She said she would turn off the UF if a patient's BP was low. She did not define low. She said she would not remove fluid from a patient with a SBP in the 90s. A second PCT, in an interview on 10/28/16 at 8:40 a.m., said if a patient's SBP reading was less that 90 she would recheck it in 15 minutes. Then if it was in the 80s she would give a saline bolus. In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager confirmed patient vital sign monitoring was not consistent with the facility policy. The Clinical Manager said she and the Medical Director had not discussed or set specific blood pressure parameters for the facility and she did not know what parameters staff used. The facility failed to ensure Patient #8's blood pressure was consistently monitored and that his hypotensive episodes were consistently identified and addressed based on his individualized needs. 4. Patient #5 was a 64 year old male who had been dialyzing at the facility since 8/1/14. Eleven treatment sheets were reviewed from 9/26/16 - 10/24/16. The treatment records documented Patient #5's blood pressure was not consistently monitored and his hypotensive episodes were not consistently identified and addressed, placing him	V 543		

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V 543	Continued From page 13 at risk of serious harm, impairment or death, as follows: - 9/28/16: Patient #5 was not identified as hypotensive in a pre dialysis nursing assessment with a BP reading of 98/52. Treatment was initiated with a UF goal of 3.5 kg. No BP was recorded for 53 minutes, from 12:40 p.m. - 1:33 p.m., and again for 48 minutes, from 2:35 p.m. - 3:23 p.m. - 9/30/16: A pre dialysis nursing assessment stated "Hypotension noted so no target UF set." Patient #5's BP was 122/71. - 10/3/16: No BP was recorded for 55 minutes, from 2:10 p.m. - 3:05 p.m. - 10/7/16: Patient #5 was not identified in a pre dialysis nursing assessment as hypotensive with a BP reading of 98/51. Treatment was initiated with a UF goal of 3 kg. - 10/10/16: A PCT note showed Patient #5's BP was 86/51 at 1:08 p.m. and said his BP would be rechecked in 15 minutes. His BP was not rechecked for 29 minutes. - 10/14/16: A PCT note showed Patient #5's BP was 89/54 at 1:02 p.m. and said his BP would be rechecked in 15 minutes. His BP was not rechecked for 31 minutes. Additionally, no BP was recorded for 49 minutes, from 3:10 p.m. - 3:59 p.m. - 10/17/16: Patient #5 presented with a 6 kg weight gain and UF goal was set for 4 kg. After 42 minutes of treatment he was identified in PCT notes as hypotensive with a BP reading of 77/45	V 543		

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V 543	Continued From page 14 at 12:35 p.m. His UF was turned off for the remainder of his treatment and his BP was to be rechecked every 15 minutes. His BP was not rechecked for 62 minutes, when it was recorded as 86/41. While his BP rose to 122/58 by the end of treatment, his UF remained off and his post dialysis weight showed he remained at 6 kg above his EDW. An RN assessment documented Patient #5's post EDW was due to "excessive fluid gain." The note did not address Patient #5's hypotension. - 10/21/16: Patient #5 presented 12.5 kg above his EDW. He was identified in a pre dialysis nursing assessment as hypotensive with a BP reading of 94/42. Treatment was initiated with a UF goal of 3 kg. After 3 minutes of treatment Patient #5's BP reading was 86/41 with no intervention. After 16 minutes of treatment, at 12:03 p.m., Patient #5's BP reading was 87/36. A PCT note said the UF was turned off and his BP was to be rechecked every 15 minutes. His BP was not rechecked for 30 minutes, when it was recorded as 75/35. His BP was not rechecked again for 27 minutes, when it was recorded as 65/35. No further interventions were documented. Patient #5's post dialysis weight was 13 kg over his EDW. A post dialysis RN note stated he "left center above DW due to excessive fluid gain." The note did not address Patient #5's hypotension. One PCT, in an interview on 10/28/16 at 8:20 a.m., said she did not believe there was a policy for blood pressure parameters but more of a nurse's directive. She said she would turn off the UF if a patient's BP was low. She did not define low. She said she would not remove fluid from a patient with a SBP in the 90s.	V 543		

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V 543	Continued From page 15 A second PCT, in an interview on 10/28/16 at 8:40 a.m., said if a patient's SBP reading was less that 90 she would recheck it in 15 minutes. Then if it was in the 80s she would give a saline bolus. In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager confirmed patient vital sign monitoring was not consistent with the facility policy. The Clinical Manager said she and the Medical Director had not discussed or set specific blood pressure parameters for the facility and she did not know what parameters staff used. The facility failed to ensure Patient #8's blood pressure was consistently monitored and that his hypotensive episodes were consistently identified and addressed based on his individualized needs. In an interview on 10/28/16 at 9:00 a.m., the Medical Director said intradialytic blood pressures needed to be considered in light of home blood pressures and a diary of home blood pressures should be kept in the patients' charts. He said special orders for individual patients' allowable blood pressures were needed, but were missing from physician's orders. He said the Initial Physicians Orders for Hemodialysis needed to be updated. The facility failed to identify acceptable upper and lower blood pressure parameters and expected interventions, allowing episodes of intradialytic hypertension and hypotension to be inconsistently identified, addressed, and monitored, which placed patients at immediate risk of serious harm, impairment or death related to broad variances in blood pressure and lack of	V 543		

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V 543	Continued From page 16 monitoring during treatments. The facility was notified of the Immediate Jeopardy on 10/28/16 at 11:30 a.m. The facility submitted a Plan of Correction on 10/28/16 at 1:00 p.m. which included a new protocol for hypertension and hypotension, including identified blood pressure parameters and expected interventions. The protocol also stated "Any technician, nurse on the floor, or care giver at any time they feel that nay [sic] patient is in clinical danger they have the responsibility of calling the doctor on call at (on call phone number)." Staff signatures, acknowledging training on the new protocol, were also included. On site-verification of the implementation of the plan occurred on 10/28/16 at 1:45 p.m. and the Immediate Jeopardy was removed.	V 543		
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Based on staff interview and QAPI meeting attendance, it was determined the facility failed to ensure an effective QAPI program was maintained that recognized and corrected problems affecting patients' health. This failure directly impacted 6 of 6 ICHD patients (Patients #5 - #10) and resulted in the inability of the facility to evaluate the quality of patient care. Findings include: 1. Refer to V628 as it relates to the facility's failure to collect and assess data related to patients' hypertension and hypotension during dialysis treatment.	V 625		11/29/16

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V 625	Continued From page 17 2. Refer to V634 as it relates to the facility's failure to collect and assess complete, accurate data related to adverse events.	V 625		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Based on QAPI documentation review and staff interview, it was determined the facility failed to ensure all facility patient outcomes were evaluated, including patients' hypertensive and hypotensive episodes. This failure directly impacted 4 of 6 ICHD patients (Patients #5, #7, #8 and #10) whose treatment records were reviewed and had the potential to impact all patients receiving care at the facility. Failure to gather and analyze adequate patient information significantly impeded the facility's ability to identify and resolve concerns of a systematic and recurrent nature. The findings include: The facility's QAPI monthly meetings were attended for Home Therapies patients, on 10/25/16, and for ICHD patients, on 10/27/16. Patient data was collected in a format developed by the facility's corporate leadership. Review showed no data was collected to indicate the facility's performance relating to patients'	V 628		11/29/16

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V 628	Continued From page 18 hypertensive and hypotensive episodes during dialysis treatments. However, patient records documented Patients #5, #7, #8 and #10 experienced hypertensive and hypotensive episodes, as follows: a. Eleven of Patient #5's treatment sheets were reviewed from 9/26/16 - 10/24/16. The records documented he experienced hypotensive episodes during no less than 6 of his 11 treatments. b. Twelve of Patient #7's treatment sheets were reviewed, from 9/26/16 - 10/24/06. The records documented he experienced hypertensive episodes during no less than 10 of his 12 treatments. c. Thirteen of Patient #8's treatment sheets were reviewed from 9/26/16 - 10/24/16. The records documented he experienced hypotensive episodes during no less than 6 of his 13 treatments. d. Eleven of Patient #10's treatment sheets were reviewed, from 9/26/16 - 10/24/16. The records documented she experienced hypertensive episodes during no less than 9 of her 11 treatments. In an interview on 10/27/16 at 4:00 p.m.,the Clinical Manager confirmed no data was collected to assess facility performance relative to patients' hypertensive and hypotensive episodes. She said chart audits were last completed in June, 2016 and the facility had addressed all identified issues at that time.	V 628		

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V 628	Continued From page 19 The facility failed to comprehensively evaluate and review patient outcomes.	V 628		
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 record review, review of the facility QAPI plan, and interview with the Clinical Manager and the Medical Director, it was determined the facility failed to ensure sufficient patient adverse event data was gathered and analyzed. This failure directly impacted 4 of 6 patients (Patients #6, #7, #9 and #10) whose records were reviewed, and had the potential to impact all patients in the facility. Failure to gather and analyze adequate patient information significantly impeded the facility's ability develop and implement appropriate corrective action plans necessary to minimize the potential for adverse event to re-occur. Findings include: A policy titled Patient Adverse Event Reporting and Documentation, revised 1/4/2012, listed numerous events that were considered to be adverse events. These included sustained loss of consciousness, blood loss >100 ml due to a clotted dialyzer, and infiltration severe enough to interfere with dialysis treatment. The policy stated "In addition to notifying the patient's treating Nephrologist, the facility Medical Director must be notified of all serious adverse	V 634		11/29/16

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V 634	Continued From page 20 events that occur or events that threaten the health and safety of patients in the facility." The policy defined a near miss as "a potential hazard or incident that has not resulted in any patient injury - but had the potential to do so." 1. Patient #6 was a 65 year old patient dialyzing at the facility. One treatment sheet, dated 10/24/16, showed nursing documentation stating "Post - Patient went unresponsive for about 30 seconds after treatment. Once she was laid back she moaned. O2 sats were 74% and bp was 74/37. Recannulated w 17 g and given NS 500 ml. Once o2 [sic] and fluid given pt improved within minutes. Left facility." When asked in an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said there was no adverse event report related to the event and she had not been made aware of the occurrence. She said she would contact the nurse for further details. Further details were provided on 10/28/16 at 8:30 a.m. It was noted Patient #6, in addition to receiving fluid, had required approximately 15 minutes of recumbent positioning and the administration of 4 liters of oxygen before returning to a normotensive, alert state. The nurse also included a note stating the event had not met criteria for an adverse event or near miss report. In an interview on 10/28/16 at 9:00 a.m., the Medical Director said he had not been made aware of the event. He said the doctor on call should have been notified of the event and the doctor would have made a decision regarding	V 634		

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V 634	Continued From page 21 further treatment needed for Patient #6. 2. Patient #9 was a 47 year old male dialyzing at the facility. One treatment sheet, dated 10/10/16, documented "off machine early due to machine clottedrefused [sic] to restring machine." Patient #9 missed 54 minutes of treatment. The post treatment nursing assessment stated "Off early at pt request with AMA signed." When asked in an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said she had not received an adverse event report related to the occurrence. She said a clotted system met criteria for an adverse event report and should have had one completed. 3. Patient #7 was a 27 year old male dialyzing at the facility. A treatment sheet, dated 10/3/16, showed no data, indicating no treatment had been received, and had no nursing documentation. A treatment sheet, dated 10/5/16, documented a pre dialysis nursing assessment stating "Pt denies any c/o other than his LUA being tender from the infiltration on Monday." In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said she did not have an adverse event report related to Patient #7 having an infiltration on 10/3/16 severe enough to interfere with his dialysis treatment. 4. Patient #10 was a 24 year old female who had dialyzed at the facility since 11/2/12. A treatment sheet, dated 10/24/16, documented Patient #10 was hypertensive in a pre treatment nursing assessment with a BP reading of 224/125. Her treatment started at 3:17 p.m. Hypertension	V 634		

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V 634	Continued From page 22 continued throughout her 3 hour and 15 minute treatment, according to RN and PCT notes, with BP readings of 227/128 at 4:01 p.m., 217/122 at 5:08 p.m., 226/106 at 5:32 p.m., and 213/124 at 6:03 p.m. Clonidine 0.3 mg was administered at 6:05 p.m., after 168 minutes of identified hypertension and 27 minutes before the end of treatment. A post treatment nursing note stated "Pt. left facility via ambulance at pt. request to go to the ER. She was having severe anxiety. HTN remains with Clonidine on board." In an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said she did not have an adverse event report related to Patient #10's transfer to the ER. The facility failed to ensure complete, accurate patient adverse event data was provided to the QAPI committee for review.	V 634		
V 710	494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined the Medical Director failed to provide sufficient oversight necessary to ensure patient care policies were adequately developed and implemented. This failure put patients at risk of inadequate care and poor outcomes. The findings include: 1. Refer to V714 as it relates to the facility's failure to ensure the Medical Director participated in the development of patient care policies and procedures that were adequate, accurate and current.	V 710		11/29/16

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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 714	494.150(c)(1) MD RESP-DEVELOP, REVIEW & APPROVE P&P The medical director must- (1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility; This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure the Medical Director participated in the development and implementation of policies that reflected the facility's current practices related to identifying and addressing patients' hypertension and hypotension during dialysis treatment. This failure resulted in inconsistent nursing practice and poor patient outcomes. The findings include: 1. A policy titled Patient Adverse Event Reporting and Documentation, revised 1/4/2012, listed numerous events that were considered to be adverse events. These included sustained loss of consciousness, blood loss >100 ml due to a clotted dialyzer, and infiltration severe enough to interfere with dialysis treatment. The policy defined a near miss as "a potential hazard or incident that has not resulted in any patient injury - but had the potential to do so." The policy stated "In addition to notifying the patient's treating Nephrologist, the facility Medical Director must be notified of all serious adverse events that occur or events that threaten the health and safety of patients in the facility." Patient Records documented Adverse Events, as follows:	V 714		11/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132511	A. BUILDING _____ B. WING _____	10/31/2016

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V 714	Continued From page 24 - 10/3/16: Patient #7 experienced an infiltration severe enough to interfere with his dialysis treatment. - 10/10/16: Patient #9 experienced a clotted dialyzer which resulted in interference with his dialysis treatment. - 10/24/16: Patient #10 experienced a hypertensive episode with such severity she received Clonidine 0.3 mg. A post treatment nursing note stated "Pt. left facility via ambulance at pt. request to go to the ER. She was having severe anxiety. HTN remains with Clonidine on board." Adverse Event Reports or other documentation that the Medical Director had been notified of the events could not be found. When asked about the above incidents, in an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said she did not have adverse event reports related to the incidents. Further, Patient #6's 10/24/16 nursing documentation stating "Post - Patient went unresponsive for about 30 seconds after treatment. Once she was laid back she moaned. O2 sats were 74% and bp was 74/37. Recannulated w 17 g and given NS 500 ml. Once o2 [sic] and fluid given pt improved within minutes. Left facility." When asked in an interview on 10/27/16 at 4:00 p.m., the Clinical Manager said there was no adverse event report related to the event and she had not been made aware of the occurrence.	V 714		

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V 714	Continued From page 25 In an interview on 10/28/16 at 9:00 a.m., the Medical Director said he had not been made aware of the event. He said the doctor on call should have been notified of the event and the doctor would have made a decision regarding further treatment needed for Patient #6. The Medical Director failed to ensure the Patient Adverse Event Reporting and Documentation policy was implemented. 2. Refer to V543 as it relates to the failure of consistent identification of, and interventions for, patients' hypotension and hypertension during dialysis treatments.	V 714		
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 operations. This failure resulted in a lack of quality patient care and a lack of patient outcome assessment. Findings include: 1. Refer to V751 as it relates to the facility's failure to ensure the Governing Body adopted and enforced policies and procedures affecting the health care and safety of patients.	V 750		11/29/16
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 responsibility for the governance and operation of the facility. The governing body adopts and	V 751		11/29/16

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V 751	Continued From page 26 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 and procedures were adopted and enforced to protect the health and safety of patients. This failure impacted all patients dialyzing at the facility, putting them at risk of unaddressed health issues. The findings include: 1. Refer to V625 Condition for Coverage: QAPI and associated standard level deficiencies as they relate to the failure of the Governing Body to ensure an effective QAPI program was maintained. 2. Refer to V710 Condition for Coverage: Responsibilities of the Medical Director and the associated standard level deficiencies as they relate to the failure of the Governing Body to ensure the Medical Director provided sufficient oversight necessary to ensure patient care policies were adequately developed and implemented.	V 751		