IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 23, 2016

Melody Nelson, Administrator
Caldwell Dialysis Center
821 South Smeed Pkwy
Caldwell, ID 83605

RE: Caldwell Dialysis Center, Provider #132518

Dear Ms. Nelson:

This is to advise you of the findings of the Medicare survey of Caldwell Dialysis Center, which was conducted on November 18, 2016.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) 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 the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **December 6, 2016,** and keep a copy for your records.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132518	A. BUILDING ______ B. WING ______	11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALDWELL DIALYSIS CENTER	821 SOUTH SMEED PKWY CALDWELL, ID 83605

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 11/14/16 - 11/18/16. The surveyors conducting the survey were: Trish O'Hara, RN, Team Leader Laura Thompson, RN Acronyms used in this report include: BLE - Bilateral Lower Extremities CSS - Clinical Services Specialist CTA - Clear To Auscultation DOE - Dyspnea On Exertion ICHD - Incenter Hemodialysis IV - Intravenous kg - kilogram L - Liter LPM - Liters Per Minute NC - Nasal Cannula O2 - Oxygen POC - Plan of Care SOB - Shortness Of Breath	V 000	RECEIVED DEC 05 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 the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Based on record review, observation, and staff	V 463	V463 100% of clinical teammates will be in-serviced on Policy 3-01-07A "Patient's Rights." Primary emphasis will be placed on item #26 of the policy which outlines the patient's right to receive necessary services as outlined in each individualized plan of care. Complete 100% of clinical teammates in-service on Policy 1-14-02 "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis" V463 cont on page 2	12/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Facility Administrator (X6) DATE: 12/2/2016

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V 463	Continued From page 1 interview, it was determined the facility failed to ensure each patient's right to receive care as outlined in their POCs was upheld for 1 of 3 ICHD patients (Patients #3) whose treatment records were reviewed. This resulted in staff not following blood pressure monitoring restrictions, which placed the patient at an increased risk for complications. Findings include: Patient #3 was a 63 year old male who Had been dialyzing at the facility since 2/06/16. Fifteen treatment records, from 10/15/16 to 11/12/16, were reviewed. Patient #3's treatment records included documentation his blood pressure was not to be monitored using either of his arms, only his legs. An observation was conducted in the facility beginning at 9:30 a.m. on 11/17/16. Patient #3 was observed during his dialysis treatment. The blood pressure cuff was on his left upper arm. During an interview on 11/17/16 at 3:45 p.m., the Charge Nurse, Facility Administrator, and acting CSS reviewed the record. The Charge Nurse stated staff were able to use Patient #3's left lower arm for blood pressure monitoring, but not the upper arm. She confirmed this was not documented in his medical chart or his treatment records. Staff failed to follow documented restrictions for monitoring Patient #3's blood pressure.	V 463	V463 Continued from page 1 and policy 1-03-08 "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment." Teammates to be instructed using surveyor observations as examples with emphasis on, but not limited to the following: based on record review facility failed to ensure each patients right to receive care as outlined in their POC. This issue resulted in staff not following blood pressure monitoring restrictions, which placed the patient at an increased risk for complications. The team in-service will be completed no later than 12/10/2016. Verification of attendance will be evidenced by a signature sheet. The FA/ designee or clinical nurse manager will complete daily post treatment audits on 10% of facility patients, focusing on physician order adherence during dialysis treatment. The FA will then complete weekly audits x two weeks on 10% of facility patients for two weeks after which time post treatment audits will be completed monthly as part of the facility's medical record audit. Teammates failing to follow policy and procedure will be counseled. The Facility Administrator (FA) will review results of audits during monthly FHM/ governing body meeting with Medical Director. FA is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	12/16/16
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients,	V 726		

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V 726	Continued From page 2 including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate treatment records for 1 of 3 ICHD patients (Patient #2) whose treatment records were reviewed. Incorrect information on the patient's treatment sheets created the potential for the patient being put at risk of complications related to inadequate fluid removal. The findings include: 1. Patient #2 was a 78 year old female who had been dialyzing at the facility since 5/14/13. Ten treatment sheets, from 10/17/16 to 11/14/16, were reviewed. a. Patient #2's record did not adequately assess pre and post dialysis condition as follows: - 10/28/16: A pre treatment nursing assessment described her respiratory status as "20;CTA;Diminished in bases, SOB/DOE;O2 3LPM/NC." Her post treatment assessment of respiratory status stated "No issues." It was not clear in the documentation if Patient #2's respiratory status had improved, deteriorated, or remained the same. On the same date a pre treatment nursing assessment documented Patient #2's edema status as "BLE 1+." It was not clear what portions of the BLE were involved. Her post treatment assessment documented her edema status as	V 726	V726 100% of clinical teammates will be in-serviced on policy 1-03-08 "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment "and "Accurate Documentation" PowerPoint presentation provided by DaVita's Clinical Services Specialist team. The in-service will include all facility RN's. Teammates to be instructed using surveyor observations as examples with emphasis on, but not limited to the following: Assessing teammates failure to document clear observations will include whether a patients status has improved, deteriorated, or stayed the same. Assessing teammate failure to document clear fluid removal and intake documentation will include fluid removal goal as well as extra fluid/food intake via oral or IV routes. Fluid/food intake to be documented during routine 30 minute vitals checks. . Team in-service will be completed no later than 12/10/2016. Verification of attendance evidenced by a signature sheet. The FA/designee or clinical nurse manager will complete daily post treatment audits on 10% of facility patients, focusing on pre and post treatment nursing assessment documentation. Then the FA will complete weekly audits on 10% of facility patients for two weeks after which time post treatment audits will be completed monthly as part of the facility's medical record audit. Teammates failing to follow policy and procedure will be counseled. The FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and sustainability of this plan of correction.	12/16/16

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V 726	Continued From page 3	V 726		

"BLE;Abdomen." It was not clear if Patient #2's BLE edema had increased, decreased, or stayed the same. Nursing documentation showed abdominal edema was not present pre treatment, but was present post treatment. No extent of involvement was documented relative to the abdominal edema.

- 10/24/16: A pre treatment nursing assessment described Patient #2's respiratory status as "20;CTA;Diminished in bases;O2 3LPM/NC." Her post treatment assessment of respiratory status stated "No issues." It was not clear in the documentation if Patient #2's respiratory status had improved, deteriorated, or remained the same.

On the same date a pre treatment nursing assessment documented Patient #2's edema status as "BLE 1+;abdomen." It was not clear what portions of the BLE were involved or how extensive the abdominal edema was. Her post treatment assessment documented her edema status as "BLE;Abdomen." It was not clear if Patient #2's BLE and abdominal edema had increased. decreased, or stayed the same.

- 10/21/16: A pre treatment nursing assessment described Patient #2's respiratory status as "20; Rhonchi throughout." A post treatment nursing assessment of respiratory status stated "No issues." It was not clear in the documentation if Patient #2's respiratory status had improved, deteriorated, or remained the same.

On the same date a pre treatment nursing assessment documented Patient #2's edema status as "BLE;Trace:Abdomen." The documentation did not describe the extent of

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V 726	Continued From page 4 abdominal edema. A post treatment assessment documented Patient #2's edema status as "BLE;Abdomen." It was not clear if her BLE and abdominal edema had increased, decreased, or stayed the same. - 10/17/16: A pre treatment nursing assessment documented Patient #2's respiratory status as "20;Diminished w/ rhonchi throughout." A post treatment nursing assessment of respiratory status stated "No issues." It was not clear in the documentation if Patient #2's respiratory status had improved, deteriorated, or remained the same. On the same date a pre treatment nursing assessment documented Patient #2's edema status as "BLE +1;Abdomen;Facial." The documentation did not describe the extent of abdominal or facial edema. A post treatment assessment documented Patient #2's edema status as "BLE;Abdomen." It was not clear if her BLE and abdominal edema had increased, decreased, or stayed the same. In an interview on 11/17/16 at 1:30 p.m., the acting CSS stated the documentation should have been more complete. The facility failed to ensure assessments were documented appropriately. b. Patient #2's record did not address discrepancies in pre and post dialysis weights as follows: - 10/17/16: Patient #2's pre dialysis weight was documented as 76.6 kg. Volume removed was recorded as 1.4 L. Post weight should have been	V 726		

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V 726	Continued From page 5 75.2 kg, but was documented as 76 kg, a difference of 0.8 kg. There was no documentation of extra fluid intake by oral or IV routes. - 10/19/16: Patient #2's pre dialysis weight was documented as 77.5 kg. Volume removed was recorded as 2.5 L. Post weight should have been 75 kg, but was documented as 76 kg, a difference of 1 kg. There was no documentation of extra fluid intake by oral or IV routes. - 10/21/16: Patient #2's pre dialysis weight was documented as 77.4 kg. Volume removed was recorded as 2.9 L. Post weight should have been 74.5 kg, but was documented as 76.1 kg, a difference of 1.6 kg. There was no documentation of extra fluid intake by oral or IV routes. - 10/24/16: Patient #2's pre dialysis weight was documented as 80.1 kg. Volume removed was recorded as 3.3 L. Post weight should have been 76.8 kg, but was documented as 77.5 kg, a difference of 0.7 kg. There was no documentation of extra fluid intake by oral or IV routes. - 10/26/16: Patient #2's pre dialysis weight was documented as 79.1 kg. Volume removed was recorded as 3.5 L. Post weight should have been 75.6 kg, but was documented as 76.8 kg, a difference of 1.2 kg. There was no documentation of extra fluid intake by oral or IV routes. - 10/28/16: Patient #2's pre dialysis weight was documented as 78.1 kg. Volume removed was recorded as 3.1 L. Post weight should have been	V 726		

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V 726	Continued From page 6 75 kg, but was documented as 75.9 kg, a difference of 0.9 kg. There was no documentation of extra fluid intake by oral or IV routes. - 11/1/16: Patient #2's pre dialysis weight was documented as 76.3 kg. Volume removed was recorded as 1.8 L. Post weight should have been 74.5 kg, but was documented as 75.3 kg, a difference of .8 kg. There was no documentation of extra fluid intake by oral or IV routes. In an interview on 11/17/16 at 1:30 p.m., the acting CSS stated any oral or IV fluids, given during treatments, should have been included in the volume to be removed. She did not have an explanation for the weight differences. The facility failed to ensure accurate weights were documented.	V 726		