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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February 21, 2017

Karin Burton, Administrator
Post Falls Dialysis
1300 East Mullan, Suite 1200
Post Falls, ID 83854-6052

RE: Post Falls Dialysis, Provider #132508

Dear Ms. Burton:

This is to advise you of the findings of the complaint survey at Post Falls Dialysis, which was concluded on February 9, 2017.

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.

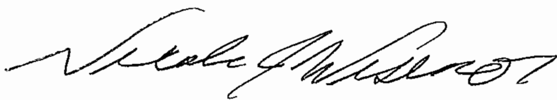
An acceptable plan of correction (PoC) contains the following elements:

- 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 **March 7, 2017**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132508	A. BUILDING ______ B. WING ______	C 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POST FALLS DIALYSIS	1300 EAST MULLAN, SUITE 1200 POST FALLS, ID 83854

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V 000	INITIAL COMMENTS The following deficiency was cited during the complaint survey at your facility from 2/6/17 - 2/9/17. The surveyors conducting the survey were: Trish O'Hara, RN, Team Leader Autumn Bernal, RN Acronyms used in this report include: BP, b/p - Blood pressure BFR - Blood Flow Rate bun - blood urea nitrogen CCHT - Certified Clinical Hemodialysis Technician DFR - Dialysate Flow Rate ICHD - Incenter Hemodialysis kg - kilogram MD - Medical Doctor ml/min - milliliter per minute ns - normal saline PCT - Patient Care Technician pt - patient RN - Registered Nurse tx - treatment	V 000	RECEIVED MAR 02 2017 FACILITY STANDARDS	
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, 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:	V 726		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Registered Nurse (X6) DATE: 3/2/2015

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 726	Continued From page 1	V 726		

Based on record review and staff interview, it was determined the facility failed to maintain accurate treatment records for 4 of 5 ICHD patients (Patients #1, #2, #4, and #5) whose treatment records were reviewed. Incorrect and/or incomplete documentation on the patients' treatment sheets created the potential for inadequate follow up care and poor patient outcomes. The findings include:

1. Patient #4 was a 71 year old male who had been dialyzing at the facility since 5/10/2016. Ten treatment records, from 1/10/17 - 2/7/17, were reviewed. Patient #4's prescription included orders for 4.25 hour treatments, 3 times a week. A Heparin bolus of 5000 units was ordered prior to initiation of treatment and Heparin was to be infused, during each treatment, at a rate of 500 units/hour. The Heparin was to be discontinued 30 minutes prior to the end of treatment, for a total of 1875 units/treatment.

a. Total Heparin infused was inaccurately documented on 40% of treatments as follows:

1/17/17: Total Heparin infused was documented as 800 units.
1/19/17: Total Heparin infused was documented as 2000 units.
1/24/17: Total Heparin infused was documented as 2200 units.
2/7/17: Total Heparin infused was documented as 0 units.

There was no documentation explaining why the Heparin was not administered as prescribed for the four treatments.

2. Patient #5 was a 68 year old male who had

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been dialyzing at the facility since 3/16/2015. Nine treatment records, from 1/11/17 - 2/6/17, were reviewed. Patient #5's prescription included orders for 3.75 hour treatments, 3 times a week. A Heparin bolus of 5000 units was ordered prior to initiation of treatment and Heparin was to be infused, during each treatment, at a rate of 500 units/hour. The Heparin was to be discontinued 90 minutes prior to the end of treatment, for a total of 1125 units/treatment.

a. Total Heparin infused was inaccurately documented on 78% of treatments as follows:

1/11/17: Total Heparin infused was documented as 100 units.
1/13/17: Total Heparin infused was documented as 1000 units.
1/26/17: Total Heparin infused was documented as 1200 units during a 2 hour treatment.
1/27/17: Total Heparin infused was documented as 0 units.
1/30/17: Total Heparin infused was documented as 1600 units.
2/3/17: Total Heparin infused was documented as 2000 units.
2/6/17: Total Heparin infused was documented as 2000 units.

There was no documentation explaining why the Heparin was not administered as prescribed for the seven treatments.

In an interview on 2/9/17 beginning at 3:00 p.m., the Clinic Manager confirmed the inaccurate Heparin dose documentation. She said all Heparin was infused via an automatic pump, incorporated into the machine, including the bolus amount. The machine accurately recorded the

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total amount administered. She said staff should have looked at the machine total and subtracted the bolus amount in order to determine the correct total amount infused before manually entering a value on the treatment sheet. She said it was possible staff were obtaining a total Heparin infused value by doing a visual exam of the syringe in the pump rather than deferring to the machine recorded value.

The Clinic Manager also said the facility had a policy instructing staff to dialyze patients without Heparin for 24 hours after any surgical procedure. She said this policy possibly was applied to Patient #4 on 2/7/17, and Patient #5 on 1/27/17. However, she said the reason for withholding Heparin should have been documented on the treatment sheet.

Additionally, Patient #5's treatment sheet for 1/25/17 documented a 46 minute treatment. The record included a nursing note stating "got infiltrated & absent sounds from the access sites, informed MD to have fistulogram tmrw [sic] AM." The treatment sheet documented Patient #5's pre weight as 73.9 kg and his post weight as 68.7 kg indicating 5.2 kg of fluid had been removed.

In an interview, on 2/9/17 beginning at 3:00 p.m., the Clinic Manager said Patient #5 did not have a 46 minute treatment on 1/25/17. She said his access was clotted, making it impossible to dialyze or remove fluid. She said the documentation for 1/25/17 was incorrect.

3. Patient #1 was a 70 year old female who had been dialyzing at the facility since 1/23/17. Seven treatment sheets, from 1/23/17 to 2/7/17, were reviewed. Patient #1's prescription included

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V 726	Continued From page 4 orders for 3 hour treatments, 3 times a week with a BFR of 400 ml/min and DFR of 600 ml/min. During review of treatment sheets there was found to be a lack of adequate documentation that clearly represented Patient #1's status and care provided. Examples included, but were not limited to, the following: a. 1/23/17: The total treatment time was documented as 1 hour and 53 minutes. No documentation was found indicating why she did not complete her total scheduled treatment. b. 1/26/17: At 9:41 a.m. Patient #1's DFR was decreased to 500 ml/min, with no documentation of why the rate was decreased. At 11:55 a.m., the PCT documented "blood returned 5 min early due to b/p dropping and patient c/o [complains of] chest pain." At 12:39 p.m. the RN documented "Tx completed, she appears anxious, encourage deep breathing exercises & helps... Pt was escorted in the lobby in stable condition." However, there was no further documentation of the RN assessing Patient #1's chest pain, if it had resolved, or if any interventions were taken to resolve the chest pain. c. 1/31/17: BFR was not delivered according to prescription as follows: At 11:01 a.m. the BFR was 450 ml/min. At 11:30 a.m. the BFR was 430 ml/min. At 12:00 p.m. the BFR was 450 ml/min. There was no documentation to indicate why the BFR was not delivered as prescribed.	V 726		

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d. 2/2/17: At 9:28 a.m. the CCHT documented a BP of 87/45 with the note, "pt syptomatic [sic] gave 200ns, patient laid back in chair, 200ns given; Oxygen Litres/Min:Nasal Cannula, 2.0." No further documentation described what symptoms were present when the patient was described as "syptomatic [sic]."

At 12:20 p.m. the RN documented "tx completed, pt denies any discomforts during tx, she pretty much slept her entire tx. Flow sheet reviewed. Removed 1.93 kg out of 3.0 kg of fluids as tolerated. Pt was escorted in the lobby in stable condition."

The RN did not document an assessment or provide any description of the episode in which Patient #1 exhibited low BP, was described as symptomatic by the CCHT, and treated with fluids.

e. 2/7/17: Nursing documentation showed Patient #1 started treatment at 10:02 a.m., experienced an episode of chest pain, and was transported to the hospital via paramedics at 12:18 p.m. The machine showed a 53 minute treatment time rather than the nurse documented treatment time of 140 minutes. Additionally, a post weight of 59 kg was documented on the treatment sheet, while Patient #1 was observed to be taken directly out of the unit on the paramedic's gurney without a post weight being taken.

In an interview on 2/9/17 beginning at 3:00 p.m., the Clinical Manager stated the facility's chest pain protocol should have been followed and should have clearly documented the assessment and interventions for the treatment of the chest

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V 726	Continued From page 6	V 726		

pain reported by the patient on 1/26/17. She stated staff should document the reason for changes from the prescribed treatment orders and variances such as treatments ending early and BFR or DFR changes. She said the Chairside computer system would not allow the closure of a treatment sheet with a blank post treatment weight, but confirmed only accurate weights should be entered..

4. Patient #2 was a 63 year old female who had been dialyzing at the facility since 9/10/15. Twelve treatment sheets, from 1/10/17 to 2/7/17, were reviewed. During record review there was found to be a lack of adequate documentation to clearly represent Patient #2's status and care provided during treatment on 1/17/17, as follows:

At 09:32 a.m. the documented BP was 165/53.
At 10:02 a.m. the documented BP was 117/46.
At 10:20 a.m. the CCHT documented "patient symptomatic, took patient off 10 mins early and drew monthly post bun lab." No corresponding vital signs were documented.
At 11:04 a.m. the RN note stated "pt appears to passes [sic] out for a second during tx, pt was on [sic] trendelenburg position, on continuous O2 for comfort, pt was initiated w/ flushes w/c [sic] helps..."
At 11:14 a.m. the CCHT documented post dialysis BP was 167/69.

There was no documentation what symptoms Patient #2 was exhibiting, the amount of fluid given during the "flushes," or a record of what her blood pressure was between 10:02 - 11:14 a.m., during or immediately following when she was documented to be "symptomatic."

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V 726	Continued From page 7 In an interview on 2/9/17 beginning at 3:00 p.m., the Clinical Manager said that vital signs should have been taken every 15 minutes after the patient had a hypotensive event. However, she said vital signs may not have been recorded if the patient was taken off of the dialysis machine. She stated that "initiated w/ flushes w/c helps," was not clear and any fluids given should have been documented in the dialysis treatment record. The facility failed to ensure documentation accurately reflected all aspects of treatments delivered to patients.	V 726		

Fresenius Kidney Care Post Falls Dialysis

CMS Provider 132508

V 726 MR-COMPLETE, ACCURATE, ACCESSABLE

The clinical manager held a meeting on 2/16/2017 with the DPC staff to review and re-educate on the following policies:

FMS-CS-IC-110-149A Nursing Supervision and Delegation

FMS-CS-IC-I-105-35C Use of the Heparin Pump,

FMS-CS-IC-I-105-035A Heparinization

FMS-CS-IC-II-125-008A, FMS-CS-IC-I-110-132APatient Evaluation Post Treatment

FMS-CS-IC-II-125-008A Complications of Hemodialysis – Management and prevention of Chest Pain

FMS-CS-IC-II-125-006A Complications of Hemodialysis – Management and Prevention of Hypotension

Effective Immediately:

- The clinical manager will audit 15% of in-center hemodialysis patient treatment sheets weekly for 4 weeks utilizing a flowsheet audit tool. Emphasis of audits will be on:
    - accurate heparinization documentation and accurate nursing documentation for any medication variance from prescription
    - accurate post treatment documentation of patient weights.
    - adherence to the patient's treatment prescription in relation to treatment time, BFR and DFR.
    - documentation of appropriate nursing assessment and interventions in response to patient complications on hemodialysis and hemodialysis prescriptions not met.
- Adherence to the policy will result in the frequency being reduced to 15% of treatment sheets reviewed bi-weekly for 2 months utilizing a flowsheet audit tool. Once compliance is sustained on-going monitoring will be done through the medical records audit per QAI calendar.
- Any on-going non-compliance by staff will be addressed with corrective action as appropriate.
- Audit results will be reviewed and presented to the QAI team beginning March 20, 2017. The QAI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight.
- The Director of Operations is responsible to ensure all documentation required to ensure the resolution of the deficiencies is provided to the QAI Committee on a monthly basis. Based on the audit results the QAI committee will make determination as to the frequency of audits moving forward.

  Completion Date: May 15, 2017

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February 22, 2017

Karin Burton, Administrator
Post Falls Dialysis
1300 East Mullan, Suite 1200
Post Falls, ID 83854-6052

Provider #132508

Dear Ms. Burton:

An unannounced on-site complaint investigation was conducted from February 6, 2017 to February 9, 2017 at Post Falls Dialysis. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007458

Allegation: The facility does not have an adequate number of staff who are adequately trained on the dialysis machines to meet all patients' needs.

Findings: An unannounced visit was made to the facility from 2/6/17 - 2/9/17. Observations were conducted, treatment records were reviewed, patient/family members and staff interviews were conducted, and patient census and staff schedules were reviewed with the following results:

Seven personnel files were reviewed. Seven files documented staff training and skills competency had been completed, by the corporate education department, within the past year. One staff had recently completed orientation while 6 staffs' dialysis experience ranged from two to nine years.

Staff scheduling was compared to patient treatments for 7 treatment days from 2/1/17 - 2/8/17. Technician to patient ratio was maintained at 1:3 or 1:4 during 6 treatment days reviewed. Registered Nurse (RN) to patient ratio was maintained at no greater than 1:12 during 6 treatment days reviewed.

Five direct care staff were interviewed. When asked, 4 of 5 staff said adequate staffing was provided to meet all patients' needs. Eight patients and/or their family members were also interviewed. When asked, 7 patients and/or their family members said all needs had been met during dialysis treatments. One patient's family member expressed concerns about the potential for patients' needs not being met.

However, 13 treatment records were reviewed for each of 5 patients. The treatment sheets documented comprehensive care was given during all treatments reviewed. Of the 65 patient treatment sheets reviewed, 1 documented a patient's momentary loss of consciousness with appropriate intervention.

Further a cumulative 11 hours of observations were conducted. During the observations it was noted that all patients' needs were met and machine alarms were addressed in a timely manner. All staff administered comprehensive treatments independently, including dialysis machine operation.

It was determined an appropriate number of adequately trained staff were provided to meet all patients' needs. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

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