IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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March 10, 2017

Trevor Pulley, Administrator
Twin Falls Dialysis Center
582 Pole Line Road
Twin Falls, ID 83301-3007

RE: Twin Falls Dialysis Center, Provider #132505

Dear Mr. Pulley:

This is to advise you of the findings of the Medicare survey of Twin Falls Dialysis Center, which was conducted on March 3, 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. 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 **March 23, 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

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

PRINTED: 03/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132505	A. BUILDING _____ B. WING _____	03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS DIALYSIS CENTER	582 POLE LINE ROAD TWIN FALLS, ID 83301

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 2/27/17 - 3/3/17. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AVF - Arteriovenous Fistula AVG - Arteriovenous Graft BFR - Blood Flow Rate BP - Blood Pressure CDC - Center for Disease Control CSS - Customer Service Specialist CVC - Central Venous Catheter ICHD - Incenter Hemodialysis ml/min - milliliters per minute NP - Nurse Practitioner PCT - Patient Care Technician POC - Plan Of Care	V 000	RECEIVED MAR 16 2017 FACILITY STANDARDS	
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure appropriate infection control measures were used by 2 of 3 PCTs (PCT A and B) observed. This created the potential for	V 113	V113 On 3/6/17 The Facility Administrator (FA) and Clinical Services Specialist CSS will in-serviced clinical team on policy 1-05-01 "Infection control for Dialysis Facilities" to ensure that teammates are following infection control guidelines to reduce opportunities for transmission of bacteria and bloodborne viral agents from patients-to-patient or healthcare worker-to-patient. The in-service provided a focus on hand hygiene and glove changes between clean and dirty tasks and artificial fingernails. V113 cont on page 2	3/31/17

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

Tina Parker | Facility Administrator | 3/14/17

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 113	Continued From page 1 cross-contamination and patients being exposed to infections. Findings include: 1. A facility policy "Infection Control For Dialysis Facilities," revised March, 2016, stated "Gloves should be changed...When going from a 'dirty' area or task to a 'clean area or task'." The policy also stated "Hand hygiene is to be performed...after the removal of gloves." During an observation on 3/1/17 from 9:00 - 11:30 a.m., PCT A was noted to be cannulating Patient #8, who was seated at Station #1. The staff unsuccessfully attempted cannulation, with gloved hands. The staff then left the station, without removing her gloves, and proceeded to the clean supply drawer containing packaged cannulation needles. The staff sorted through the contents of the drawer. Not finding the required needle in the drawer, the staff then proceeded to the storage room, in another part of the facility, to obtain a replacement needle. After placing the replacement needle on the chairside tray in Station #1, the staff removed her gloves. She then proceeded to another area of the facility without performing hand hygiene after removing her gloves. When asked, at the time, if gloves should have been removed and hand hygiene performed when leaving Station #1, the staff replied "Probably." 2. CDC recommendations for Healthcare Providers, April 28, 2016, stated "Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. It is recommended that healthcare providers do not wear artificial fingernails or	V 113	V113 Continued from page 1 Surveyor findings were also shared with the team to include: 1) after unsuccessful cannulation attempt, staff left station without removing gloves and proceeded to clean supply drawer, then proceeded to storage room to obtain replacement. After obtaining replacement removed gloves – did not perform hand hygiene. 2) PCT observed providing direct patient care while wearing artificial fingernails. Verification of training is evidences with a signature sign in sheet. The FA or designee will complete and infection control observational audit daily X 2 weeks then weekly X for CS 1 X weeks. Additionally the facility will be completing the CDC infection control audits In as part of a NW project and will be attending monthly calls on Infection Control/BSI. Teammates failing to follow policy and procedure will be counseled.. Audit results from all audits will be reviewed in Teammate Meetings monthly. The FA will assign a teammate co-champion with Infection Control Manager to help with infection control. Ongoing compliance will be monitored with the monthly Infection Control Audit. The FA will review audit findings with the Medical Director monthly during QAPI/Facility Health Meeting (FHM). The FA is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/31/17

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V 113	Continued From page 2 extensions when having direct contact with patients at high risk." Facility policy #1-05-01, titled Infection Control For Dialysis Facilities, revised March, 2016, stated "It is a requirement for all [company name] teammates whose primary location is working in a facility to have only natural nails. Artificial fingernails, nail extenders or nail enhancements including but not limited to nail jewelry, sculptor, acrylic or resin overlays or bonding, gels, tips, wraps, hybrid gels are not permitted." During an observation on 2/28/17 from 1:00 - 2:10 p.m. PCT B was observed providing direct patient care to three patients while wearing artificial fingernails. The staff performed hand hygiene several times during patient care, using an alcohol based hand rub. In an interview on 3/2/17 at 4:00 p.m., the CSS confirmed the facility policy and said the staff should not have been wearing artificial fingernails while delivering direct patient care. The facility failed to ensure measures were taken by staff to prevent contaminant transmission to patients.	V 113		
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;	V 463		

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V 463	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the facility failed to ensure each patient's right to receive care as outlined in their POCs was upheld for 3 of 7 ICHD patients (Patients #3,#5 and #6) whose treatment records were reviewed. This resulted in blood flow rates not being delivered as ordered, which placed the patients at risk for decreased adequacy and/or access complications. Findings include: 1. Patient #5 was a 65 year old female who started dialysis at the facility on 1/31/17 using a CVC and later transitioning to an AVG. Thirteen treatment records were reviewed from 1/31/17 - 2/27/17. Patient #5's ordered BFR of 300 ml/min was not implemented during 10 treatments, with no documentation showing efforts were made to attain the ordered BFR, as follows: 1/31/17 - Average BFR 185 ml/min. 2/1/17 - Average BFR 210 ml/min. 2/3/17 - Average BFR 190 ml/min. 2/6/17 - Average BFR 263 ml/min. 2/8/17 - Average BFR 220 ml/min. 2/10/17 - Average BFR 248 ml/min. 2/17/17 - Average BFR 255 ml/min. 2/22/17 - Average BFR 250 ml/min. 2/24/17 - Average BFR 387 ml/min. 2/27/17 - Average BFR 268 ml/min. 2. Patient #6 was a 60 year old female who was admitted to the facility on 7/8/16. She had returned to the facility on 2/16/17, after a hospitalization, using an AVF for treatments. Four treatment records were reviewed from 2/16/17 - 2/24/17. Patient #6's ordered BFR of 300 ml/min was not implemented during 4 treatments, with no documentation indicating why	V 463	V463 In-service was completed on 3/6/17 regarding policy 1-03-08 "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" and policy 1-03-08A "Treatment Initiation". Surveyor findings were also shared with the team to include: 1) Patients ordered BFR 300 ml/min not implemented during 10 treatments, with no documentation showing efforts were made to attain the ordered BFR; 2) Patients ordered BRF of 300 ml/min was not implemented during 4 treatments, with no documentation indicating why the ordered BFR had been exceeded; delivered BFR exceeded recommendations for 16 g needle size; 3) Pt ordered BFR of 450 ml/min not implemented during 5 treatments without documentation indicating why the ordered BFR was not been attained. Verification of training is evidences with a signature sign in sheet. Beginning week of March 6, 2017 the FA or designee will be doing post treatment audits daily x 1 week on all patients, then on 50% of patients daily x 3 weeks, then on 10% of patients daily x 5 months. Facility Administrator will be doing 10% of audits for each step. Ongoing the FA or designee will complete a review of 10% of post treatment audits per month. The FA will review audit findings with the Medical Director monthly during QAPI/Facility Health Meeting (FHM). The FA is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/31/17

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V 463	Continued From page 4 the ordered BFR had been exceeded,as follows: 2/16/17 - Average BFR 400 ml/min. 2/18/16 - Average BFR 381 ml/min. 2/21/17 - Average BFR 374 ml/min. 2/24/17 - Average BFR 400 ml/min. Additionally, 16 gauge needles were ordered for use in cannulating Patient #6's AVF. Directions were posted in the treatment area, for staff reference, stating BFR should be maintained at 250 - 350 ml/min while using 16 gauge needles for an AVF. 3. Patient #3 was a 33 year old male who had been dialyzing at the facility since 8/1/16 using an AVG for treatments. Twelve treatment records were reviewed from 1/30/17 - 2/27/17. Patient #3's ordered BFR of 450 ml/min was not implemented during 5 treatments, with no documentation indicating why the ordered BFR had not been attained, as follows: 1/30/17 - Average BFR 421 ml/min. 2/3/17 - Average BFR 425 ml/min. 2/10/17 - Average BFR 434 ml/min. 2/20/17 - Average BFR 403 ml/min. 2/27/17 - Average BFR 414 ml/min. In an interview on 3/2/17 at 3:00 p.m., the Nurse Manager confirmed the BFR variances for Patients #3, #5, and #6. She said the patients' BFRs should have been maintained as ordered. The facility failed to ensure patient treatments were delivered as ordered.	V 463		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE	V 726		

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V 726	Continued From page 5 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: Based on record review and staff interview, it was determined the facility failed to maintain accurate treatment records. The lack of documentation indicating pertinent information, as well as the condition of patients, directly impacted 3 of 7 ICHD patients (Patients #2, #3, and #5) and had the potential to impact all patients dialyzing at the facility. This failure allowed the potential for inadequate treatments being administered to patients. The findings include: 1. Patient #2 was a 31 year old female who had been dialyzing at the facility since 7/14/07. Thirteen treatment records from 1/28/17 -2/25/17 were reviewed. Nine records showed Patient #2 was severely hypertensive as noted by the following pre and post treatment standing blood pressures: 1/28/17 - Pre treatment BP was 193/131, post treatment BP was 208/126. 1/31/17 - Pre treatment BP was 229/141, post treatment BP was 239/153. 2/2/17 - Pre treatment BP was 213/139, post treatment BP was 208/132. 2/4/17 - Pre treatment BP was 197/131, post treatment BP was 213/134. 2/6/17 - Pre treatment BP was 206/131, post treatment BP was 203/136.	V 726	V726 An In-service was will be completed on 3/6/17 regarding policy 1-03-08 "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" and policy 1-03-08A "Treatment Initiation". Surveyor findings were also shared to include: 1) No documentation was present on the 9 treatment records or in nursing narrative notes, indicating the physician or extender had been made aware of patient's hypertension, 2) Patient dialysis was ordered for 180 minutes 3 X week, treatments had been shortened 12 times. Treatment sheets did not document time was offered to patient to make up missed dialysis time; 3) Ten records showing patient to be severely hypertensive, no documentation present on the 10 records or in nursing narrative indicating the physician or extender has been made aware; 4) No note indicating transition from CVC to AVG – no secondary access noted. Verification of training is evidences with a signature sign in sheet. Beginning week of March 6, 2017 the Facility Administrator or designee complete post treatment audits daily x 1 week on all patients, then daily on 50% of patients , then daily X 5 months on 10% of patients. Ongoing the FA or designee will complete a review of 10% of post treatment audits per month. The FA will review audit findings with the Medical Director monthly during QAPI/Facility Health Meeting (FHM). The FA is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/31/17

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V 726	Continued From page 6 2/9/17 - Pre treatment BP was 166/96, post treatment BP was 177/107. 2/11/17 - Pre treatment BP was 183/102, post treatment BP was 182/111. 2/14/17 - Pre treatment BP was 208/128, post treatment BP was 200/128. 2/16/17 - Pre treatment BP was 211/135, post treatment BP was 196/111. No documentation was present on the 9 treatment records, or in nursing narrative notes, indicating the physician or extender had been made aware of Patient #2's hypertension. In an interview on 3/2/17 at 3:00 p.m., the Nurse Manager confirmed the lack of documentation. She said the physician's extender, a NP, was usually present at the facility on 2 of the 3 days a week Patient #2 dialyzed. She said the NP was notified verbally if Patient #2 was hypertensive before, during, or after her treatments. Additionally, Patient #2's dialysis was ordered for 180 minutes, 3 times a week. During the review of thirteen treatment records, from 1/28/17 - 2/25/17, it was noted that Patient #2's treatments had been shortened 12 times. Treatment sheets did not document time was offered to Patient #2, by staff, to make up missed dialysis time on 2/9/17, 2/11/17, 2/16/17, 2/21/17, and 2/25/17. The total time missed on those dates was 5 hours 36 minutes. In an interview on 3/2/17 at 3:00 p.m., the Nurse Manager confirmed the lack of documentation. She said she did not know if extra time had been offered to Patient #2 on those dates. 2. Patient #3 was a 33 year old male who had	V 726		

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V 726	Continued From page 7 dialyzed at the facility since 8/1/16. Twelve treatment records, from 1/27/17 - 2/27/17, were reviewed. Ten records showed Patient #3 to be severely hypertensive as noted by the following pre and post treatment standing blood pressures: 1/27/17 - Pre treatment BP was 170/108, post treatment BP was 191/106. 1/30/17 - Pre treatment BP was 197/122, post treatment BP was 189/111. 2/1/17 - Pre treatment BP was 190/118, post treatment BP was 178/99. 2/3/17 - Pre treatment BP was 189/121, post treatment BP was 180/100. 2/6/17 - Pre treatment BP was 185/107, post treatment BP was 184/107. 2/8/17 - Pre treatment BP was 166/102, post treatment BP was 181/92. 2/10/17 - Pre treatment BP was 176/107, post treatment BP was 161/96 2/13/17 - Pre treatment BP was 181/105, post treatment BP was 169/99. 2/20/17 - Pre treatment BP was 160/104, post treatment BP was 166/100. 2/24/17 - Pre treatment BP was 149/102, post treatment BP was 157/110. No documentation was present on the ten treatment records, or in nursing narrative notes, indicating the physician or extender had been made aware of Patient #3's hypertension. In an interview on 3/2/17 at 3:00 p.m., the Nurse Manager confirmed the lack of documentation. She said the physician's extender, a NP, was usually present at the facility on 3 of the 3 days a week Patient #3 dialyzed. She said the NP was notified verbally if Patient #3 was hypertensive before, during, or after his treatments.	V 726		

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V 726	Continued From page 8 3. Patient #5 was a 65 year old female who started dialysis at the facility on 1/31/17 using a CVC access and transitioning to an AVG. However, it was unclear in the treatment record when the transition took place as follows: 2/8/17 - Patient #2's treatment sheet showed her primary access was a right CVC with no secondary access noted. No cannulation needle size was ordered, and Heparin was ordered to be administered throughout the treatment (a customary procedure when using a CVC). A nursing post assessment stated "using graft, no problems." 2/10/17 - The treatment sheet showed Patient #2's primary access was a right CVC with no secondary access noted. Cannulation needle size was ordered as 16 gauge and Heparin administration was ordered to be discontinued 60 minutes before the end of treatment (a customary procedure when using an extremity access). Nursing documentation included "Treatment initiated" and "Pt has pain in left arm, feeling hot." 2/13/17 - The treatment sheet showed Patient #2's primary access was a right CVC with no secondary access noted. Cannulation needle size was ordered as 16 gauge and Heparin administration was ordered to be discontinued 60 minutes before the end of treatment. A nursing post treatment assessment stated "used AV graft." 2/15/17 - The treatment sheet showed Patient #2's primary access was identified as upper left arm AV Graft.	V 726		

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TWIN FALLS DIALYSIS CENTER	582 POLE LINE ROAD TWIN FALLS, ID 83301

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V 726	Continued From page 9 In an interview on 3/2/17 at 3:00 p.m., the Nurse Manager said the orders for cannulation needle size, the Heparin orders, and the primary access site should have been changed at the time Patient #2's left upper arm AVG was initially used. She said the orders did not clearly indicate when the AVG was initially cannulated. The facility failed to ensure complete and accurate medical records were maintained for patients.	V 726		