IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 12, 2017

Melissa Oberti, Administrator
Table Rock Dialysis Center
5610 West Gage Street, Suite B
Boise, ID 83706

RE: Table Rock Dialysis Center, Provider #132502

Dear Ms. Oberti:

Based on the Recertification and Complaint survey completed at Table Rock Dialysis Center, on December 4, 2017, by our staff, we have determined Table Rock Dialysis Center is out of compliance with the Medicare ESRD Conditions for Coverage of **CFC-Patients Rights (42 CFR 494.70), 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 Table Rock Dialysis Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before January 18, 2018. 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 January 10, 2018.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **December 26, 2017**.

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
Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 and complaint survey at your facility from 11/2817 - 12/01/17. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AMA - Against Medical Advice AOR - Adverse Occurence Report b/c - because BR - Bathroom CVC - Central Venous Catheter d/t - due to FA - Facility Administrator hr - hour ICHD - Incenter Hemodialysis mg - milligram ml - milliliter PCT - Patient Care Technician POC - Plan of Care pt - patient RN - Registered Nurse SBA - standby assist SNF - Skilled Nursing Facility SW - Social Worker tx - treatment w/c - wheelchair	V 000		
V 111	IC-SANITARY ENVIRONMENT CFR(s): 494.30 The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and	V 111		

RECEIVED
DEC 21 2017
FACILITY STANDARDS

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

M Scott Hardwick Facility administrator 12/21/17

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.

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	6610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 111	Continued From page 1 between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a sanitary environment. This failure directly impacted 2 of 11 ICHD patients (Patients #2 and #7) whose treatments were observed or reviewed and had the potential to impact all patients dialyzing at the facility. This resulted in the potential transmission of infection through cross contamination. The findings include: 1. On 11/28/17 at 5:30 P.M., a PCT was preparing to discontinue treatment for Patient #2. The PCT performed hand hygiene and put on a pair of clean gloves. She then placed her hand, palm down, on a rolling stool and moved it to the chairside. The rolling stool had been used by several staff members, at several patient stations to sit at the chairside, with no disinfection observed. The PCT then proceeded, with the same gloved hands, to decannulate the patient. In an interview on 11/28/17 at 6:00 P.M., the FA said the PCT should have changed gloves and performed hand hygiene after contacting the stool with her hand and before touching the patient's access. 2. On 12/4 17 at 2:15 P.M., the pneumatic lift was observed to be used to transfer Patient #7 to his treatment chair. The lift was then returned to the storage area used for the lift and also housing office supplies and a copy machine. No disinfection of the lift was observed. When asked at the time, a PCT stated it was	V 111	V111 In-service provided to all clinical teammates on Policy 1-05-01 "Infection Control for Dialysis Facilities" by facility preceptor(s) with a focus on prevention of infection through cross contamination from patient-to-patient and/or healthcare worker-to-patient transmission. Specific examples were offered during the course of our CMS re-certification by our surveyor that were also used during these meetings to illustrate opportunities for improved practice: First, it was noted that gloves are considered contaminated once they come into contact with a dirty surface (such as a stool), and are no longer acceptable to use for patient care. Second, it was noted that ancillary equipment used for multiple patients (the mechanical lift, for example) should be proper disinfected after each use. This in-service occurred in homeroom meetings between 11/30/2017 and 12/1/2017 as evidenced by a signature sheet. Beginning the week of December 18, 2007 the Facility Administrator (FA), Facility Infection Manager, or designee will be doing an infection control audit daily X2 weeks on random shifts, then weekly X4 weeks, then twice a month x 2 months. Teammates failing to follow policy and procedure will be counseled. Ongoing compliance will be monitored with the facility infection control audit monthly. The infection control audit will be reviewed with the Medical Director at the QAPI/PHM every month. The FA is responsible for the implementation, monitoring and ongoing compliance with this Plan of correction.	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	6610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 111	Continued From page 2 facility policy to disinfect the lift with diluted bleach water after patient use and prior to storage. The facility failed to maintain a sanitary environment.	V 111		
V 450	CFC-PATIENTS- RIGHTS CFR(s): 494.70 This CONDITION is not met as evidenced by: Based on observation, policy review and staff interviews, it was determined the facility failed to treat patients with dignity and follow their POCs. The cumulative effects of these failures resulted in patients' individual needs not being addressed and patients not receiving care as ordered by the physician. The findings include: 1. Refer to V452 as it relates to the facility's failure to uphold patients' rights to dignity and respect. 2. Refer to V463 as it relates to the facility's failure to provide care as prescribed by the physician.	V 450	V450 Members of the Governing Body (GB) have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Conditions of Patients-Rights (V450) that are not met, as well as other standards, contain specifics of corrective plans. The Governing Body will meet weekly to ensure compliance with the POC. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi-annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC. Refer to V452 and V463 for specific plans of correction.	1/3/18
V 452	PR-RESPECT & DIGNITY CFR(s): 494.70(a)(1) The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on observation, policy review and staff	V 452	V452 The facility's Patient Right's document is given to all patients on admission, and is posted in the clinic lobby area. 100% of teammates to be in-serviced on the facility's Patient Rights document, with a specific focus on how this document relates to the toileting needs of patients, especially those dependent on a mechanical lift for safe transfer. During these meetings the team will also review Policy 4-08-18 "Use of Mechanical Device for Lifting	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 452	Continued From page 3 interview, it was determined the facility failed to ensure that 1 of 2 patients (Patient #6) who was transferred using a pneumatic lift to and from a wheelchair, was treated with respect, dignity, and sensitivity to individualized toileting needs. This resulted in a patient, who was non-ambulatory, not being able to access the facility's bathroom. The findings include: The facility's Patient's Rights document, dated 6/30/17, was given to all patients at admission as well as being posted in the lobby area. The document stated "As a [facility name] patient I understand I am entitled to the following...To be treated with (i) respect, dignity, and recognition of my individuality, choices, strengths, abilities, cultural values, religious beliefs, and personal needs, to the extent possible during treatment..." 1. The record for Patient #6 was reviewed and documented the following: a. Patient #6 was an 82 year old female with an initial date of dialysis of 7/08/17. Her initial POC, dated 8/03/17, stated her functional status was wheelchair transfer with a one person assist. A SW note, dated 10/31/17, stated the SW had spoken with Patient #6's daughter. The note stated "SW explained that if the pt is a Hoyer transfer, that she will not be able to go to the bathroom while at tx and will have to discontinue tx for the day and go back to her SNF to go to the bathroom (b/c the patient cannot use the bathroom with the Hoyer sling.)" Patient #6's treatment sheet for 11/09/17 documented a treatment shortened by 74 minutes as well as a nursing note stating "Off	V 452	V452 Continued from page 3 Patients," as well as Policy 1-05-17 "Care of Patients who are Incontinent of Bowel While on Dialysis," to better address patient needs while on dialysis. These in-services to be done in homeroom meetings during the month of December (and January if needed), and will be evidenced by signature sheets. Team will continue to offer make-up treatment time for any time missed as a result of a patient request to end treatment early. Facility will carry toileting supplies including urinals (both male and female variety), privacy screens and disposal undergarments (attends). The IDT will arrange a care conference with the care facility to discuss possible solutions for this patient. Documentation of this care conference will be reviewed in the patients care conference. Until such time as this patient's treatment time can be stabilized the patient will be flagged as unstable and a care plan completed monthly. Written guidance will be provided to 100% of teammates including all members of the IDT with respect to patients who are dependent on mechanical lift for transfer. This guidance will outline the evaluation of patients for dependency on mechanical lift assistance for safe transfer, and communication with the patient's family and/or care facility to promote a more cohesive plan of care. The Mechanical Lift Assistance list will be reviewed with the Medical Director at the QAPI/FHM every month. The FA is responsible for the implementation, monitoring and ongoing compliance with this Plan of correction .	1/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 452	Continued From page 4 early to use the bathroom. Pt needing constant reminders that if she needs to use bathroom she will have to end tx and go to care center as she is max assist and hoyer sling which we aren't able to transfer to toilet with. AMA signed." A nursing progress note, dated 11/11/17, stated "Patient came to treatment and as she was being transferred said she had diarrhea and needed to go to the bathroom. She is a max assist and is now a hoyer transfer. Patient was explained this and asked if it was possible for her to wait. She said she would not be able to wait and needed to go to the bathroom. Patient was given the option to be cleaned up in the chair..." No dialysis treatment was recorded for the day. Patient #6's treatment sheet for 11/14/17 documented a treatment shortened by 173 minutes as well as a nursing note stating "Pt requested to use restroom. Explained that she just started tx. Explained to pt again policy about hoyer pts using restroom. I called transportation." During an observation on 11/28/17 at 5:45 P.M., Patient #6 asked the PCT three times to use the restroom. The PCT refused the request three times, telling Patient #6 that because she used a pneumatic lift for transfers, the staff was unable to take her to the restroom. The PCT also told Patient #6 the pneumatic lift would not fit through the bathroom door. When asked, at the time of the observation, the PCT and the RN said it was the facility policy to end treatment and return patients to their care facility for toileting if a pneumatic lift was used for transfers.	V 452		

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 452	Continued From page 5 A monthly progress note, dated 11/28/17, stated "The patient still requires education/reminding that the staff is not able to accommodate taking her to the restroom d/t the hoyer lift." The same note stated "Patient was not pleased with the clinical staff when she was informed that we would not be taking her to the restroom anymore during treatments." In an interview on 11/28/17 at 6:00 P.M., the FA confirmed the practice of returning patients to their care facility for toileting. When asked if other toileting options were available, such as a toileting sling or bedpans, he stated other options were not available at the facility. The facility failed to treat patients with respect and dignity relating to toileting.	V 452		
V 463	PR-RECEIVE SERVICES OUTLINED IN POC CFR(s): 494.70(a)(12) 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 interview, it was determined the facility failed to ensure patients' rights to receive care as outlined in their POCs were upheld for 4 of 11 ICHD patients (Patients #4, #6, #8, and #9) whose treatments were observed or reviewed. This resulted in patients not receiving medication and dialysis time as prescribed. The findings include:	V 463	V463 All clinical teammates to be in-serviced by FA or preceptor on Policy 1-01-09 "Shortened/ Early Termination of Treatment or Extended Treatment", and associated form Policy 1-01-09A "Early Termination of Treatment against Medical Advice." In-service will emphasize the patient's right to receiving a full dialysis treatment, and discuss offering make-up treatment time to patients who, for reasons out of their control, miss any part of their prescribed treatment. All clinical teammates will be in-serviced on DaVita education "Tips to Reduce Missed Treatments", as well as Policy 1-01-10 "Refusal of Care / Treatment Against Medical Advice" by FA or preceptor, with a focus on the current processes in place for intervention and documentation when a patient refuses/misses treatment. V463 cont on page 7	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 463	Continued From page 6 1. Patient #6 was an 82 year old female who had dialyzed at the facility since 7/08/17. Her dialysis prescription ordered a 225 minute treatment three times a week. a. A review of 13 treatment records from 10/28/17 - 11/25/17 documented the following: - A treatment on 10/28/17 was shortened by 20 minutes. - A treatment on 11/04/17 was shortened by 72 minutes. - A treatment on 11/09/17 was shortened by 74 minutes. - A treatment on 11/11/17 was missed. - A treatment on 11/14/17 was shortened by 173 minutes. - A treatment on 11/18/17 was shortened by 30 minutes. This represented a loss of 594 minutes of dialysis time during one month. The opportunity to make up the lost time was documented one time, on 11/04/17. b. Patient #6's prescription included the administration of Venofer (an iron medication) 50 mg weekly, to be given each Tuesday. Patient #6's termination of treatment was observed on 11/28/17. Her blood was rinsed back from the tubing and her CVC ports were packed and capped. A 1 ml syringe remained attached to the tubing, at the end of treatment. The syringe was labeled "Venofer 50 mg/ml." The syringe contained 1/2 ml of Venofer. When asked at the time, the RN confirmed Patient #6 should have received the remaining	V 463	V463 Continued from page 6 All clinical teammates will be in-serviced by Facility Administrator on Policy 1-06-01 "Medication Policy", with a focus on verifying all IV medications have been given prior to discontinuing treatment, as well as correct entry of medication orders into Snappy (especially in abnormal circumstance, i.e. running patients four days a week). In-service will also cover Policy 13-01-02 "Adverse Occurrence Reporting Policy" to emphasize the importance of documenting medication errors and respective interventions. All clinical teammates will be in-serviced by Facility Administrator on Policy 1-03-08 "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment" to emphasize the need to document deviations from treatment, notify the licensed Nurse and for the Nurse to document his/her response. All in-services will occur in home room meetings in December 2017 as evidenced by signature pages. The FA or designee will complete 100% flowsheet reviews daily X 1 week, then 50% flowsheet reviews weekly X 2. Teammates failing to follow policy and procedure will be counseled. Ongoing compliance will be monitored with a 10% flowsheet review monthly. The results of the flow sheet audits will be reviewed with the Medical Director at the QAPI/FHM every month. The FA is responsible for the implementation, monitoring and ongoing compliance with this Plan of correction.	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	6610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 463	Continued From page 7 Venofer prior to the end of her treatment. Patient #6 did not receive her medication as prescribed. 2. Patient #4 was a 53 year old male who had dialyzed at the facility since 2/26/10. His dialysis prescription ordered 240 minute treatments three times a week. A treatment sheet, on 11/19/17, documented treatment starting at 6:03 A.M. and ending at 10:03 A.M. Further documentation showed he was "off to use bathroom" at 9:07 A.M. and "back from bathroom" at 9:30 A.M. In an interview on 11/30/17 at 3:00 P.M., the FA confirmed the documentation indicated Patient #4's machine was not paused during the 23 minutes he spent in the restroom, and Patient #4 had not received his prescribed dialysis time. Patient #4 did not receive his dialysis treatment time as prescribed. 3. Patient #9 was a 32 year old female who had been dialyzing at the facility since 5/08/17. Her dialysis prescription ordered Heparin 500 units/hr for her 3.5 hour treatment, for a total of 1750 units. A treatment sheet, on 11/13/17 documented Patient #9 received 1200 units of Heparin during her treatment. A nursing note for that day stated "set incorrectly." No AOR could be found showing the medication error had been reported. In an interview on 11/30/17 at 3:00 P.M., the FA confirmed the medication error for Patient #9.	V 463		

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 463	Continued From page 8 Patient #9 did not receive her medication as ordered. 4. Patient #8 was a 52 year old female who had dialyzed at the facility since 4/28/17. Her dialysis prescription ordered a 150 minute treatment 4 times a week on M/W/F/Sat. She dialyzed using a CVC with continuous Heparin infusion during treatments to prevent clotting. Seventeen treatments from 10/28/17 - 11/25/17 were reviewed. During 13 treatments, Heparin was shown to be infused for the entire treatment. During 4 Saturday treatments on 10/28/17, 11/04/17, 11/11/17, and 11/25/17 the Heparin infusion was shown to be discontinued 60 minutes before the end of treatment. Additionally, Patient #8's Heparin infusion rate was shown as 1000 units/hr on M/W/F and 500 units/Hr on Sat. In an interview on 11/30/17 at 3:00 P.M., the FA explained the discrepancies were due to the facility's software system. He said orders could be entered only for M/W/F treatment days or T/Th/ Sat treatment days. If a patient had treatments four days a week, the orders needed to be entered twice. He said Patient #8's orders had been entered incorrectly for her Saturday treatments and she should have received Heparin 1000 units/hr, for the entire treatment, on all treatment days. No AORs could be found showing the medication errors had been reported. During review of Patient #8's 17 treatment sheets, missed treatments were noted on 11/04/17, 11/11/17, and 11/17/17. Her treatment	V 463		

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 463	Continued From page 9 on 11/13/17 was shortened by 30 minutes, her treatment on 11/24/17 was shortened by 12 minutes, and her treatment on 11/27/17 was shortened by 8 minutes. This was a loss of 500 minutes of dialysis time in 1 month. There was no documentation Patient #8 had been offered the opportunity to make up the missed or shortened treatments. In an interview on 11/30/17 at 3:00 P.M., the FA confirmed Patient #8's missed and shortened treatments and said make up time should have been offered and documented. Patient #8 did not receive her dialysis time and medication as ordered.	V 463		
V 520	PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO CFR(s): 494.80(d)(2) In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by:	V 520	V520 All members of the core team (Clinical Nurse Manager, Dietitian, Social Worker, and FA) to be in-serviced by Clinical Services Specialist (CSS) on DaVita's "Guidelines for Unstable Criteria for Interdisciplinary Assessments and POC". Charge nurses will also be in-serviced on these criteria on a one-on-one basis by the FA by 12/31/2017. All in-services evidenced by signature sheets. The core team will continue to meet with the rest of the IDT at least monthly to review which patients should be considered either stable or unstable during the monthly IDT meeting, and will make adjustments to assessments and POCs as appropriate. Special attention will be paid to significant, long-term changes in ambulatory and/or transfer status, at which point patients may be considered unstable. Written guidance will be provided to 100% of teammates including all members of the IDT with respect V520 cont on page 11	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 520	Continued From page 10 Based on staff interview, record review, and policy review, it was determined the facility failed to ensure patients were identified as unstable and reassessed on a monthly basis with appropriate changes to their active POCs. This directly impacted 2 of 11 patients (Patients #6 and #7), whose records were reviewed, and had the potential to impact all patients receiving treatment at the facility. This resulted in patients not being reassessed, and POCs not being revised, when deteriorating health status occurred. The findings include: A policy, titled Assessment Scenarios Workflow, undated, stated nursing assessments would be performed for unstable patients on the day the instability was noted. A document, titled Guidelines for Unstable Criteria for Interdisciplinary Assessments and POC, dated 10/15/16, gave minimum criteria for identifying patients as unstable. The criteria included deterioration in mental or functional status, and a change in ambulation severe enough to interfere with the patient's ability to follow aspects of the treatment plan. During the survey entrance conference on 11/28/17 at 9:00 A.M., the FA provided documentation stating no ICHD patients presently met unstable criteria. 1. Patient #6 was an 82 year old female who had been dialyzing since 07/08/17. She resided at a SNF. Her initial POC, dated 08/03/17, included a category titled Health maint/Safety. This category documented a note by an RN stating "Patient is a	V 520	V520 Continued from page 10 to patients who are dependent on mechanical lift for transfer. This guidance will outline the evaluation of patients for dependency on mechanical lift assistance for safe transfer, and communication with the patient's family and/ or care facility to promote a more cohesive plan of care. The Mechanical Lift Assistance list will be reviewed with the Medical Director at the QAPI/FHM every month. Patient stability status and care plan and assessment completions status will be reviewed monthly in FHM with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this Plan of correction.	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 520	Continued From page 11 wheelchair transfer. Patient is a one person assist to/from treatment chair." An RN progress note, dated 9/12/17, stated "Patient is a wheelchair transfer. Patient is a one person assist to/from treatment chair. No falls in the last 60 days." An RN progress note, dated 10/27/17, stated "One person assist, no falls." An RN note, dated 11/14/17, stated "Patient now hoyer lift due to patient safety with transfer, multiple discussions with pt today regarding personal safety and frequent requests to use the BR...pt has been hoyer lift transfer last several treatments." Patient #6 was observed to be transferred from her treatment chair using a pneumatic lift on 11/28/17 at 5:45 P.M. There was no documentation showing Patient #6 had been identified as unstable, due to deterioration of functional status, between 10/27/17 and 11/14/17. No reassessment had been done during that time, and there was no documentation explaining why a pneumatic lift was being used for transfer or who had authorized the use of a lift. In an interview on 11/28/17 at 6:00 P.M., the FA was asked who was able to authorize the use of a pneumatic lift. He said "anyone" could make that change. In an interview on 11/29/17 at 9:00 A.M., the SNF charge nurse stated Patient #6 did not use a pneumatic lift for transfers at the SNF, and	V 520		

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 520	Continued From page 12 transferred using a one person assisted stand/pivot. 2. Patient #7 was a 74 year old male who had started dialysis on 11/15/17. He resided in a SNF. Because he was a new patient, no POC had been implemented. A New Patient Pre Treatment Evaluation Form, dated 11/15/17, identified Patient #7's mobility as "w/c." An RN progress note, dated 11/15/17, documented "Pt non ambulatory, uses wheelchair, able to transfer to hemodialysis chair with 1 assist pivot transfer to HD chair. He did have hoyer sling in wheelchair but reports he does not need to be a hoyer transfer...Pt transferred to HD chair with 1 assist, steady with assist." His pre and post treatment assessments on 11/15/17 documented Patient #7 transferred to and from the treatment chair using an assisted pivot. Patient #7's 11/17/17 treatment sheet documented a pneumatic lift was used to transfer to and from the treatment chair. His 11/20/17 treatment sheet documented a pneumatic lift was used to transfer Patient #7 to the treatment chair. However, a post treatment note documented Patient #7 was "able to self transfer to wheelchair with SBA, steady." Treatment sheets from 11/22/17 through 11/29/17 documented a pneumatic lift was used to transfer Patient #7 to and from the treatment chair. No documentation was present indicating why a pneumatic lift was used for transfer.	V 520		

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 520	Continued From page 13 An RN progress note, dated 11/29/17, did not address Patient #7's mobility status. On 12/01/17 at 2:15 P.M., Patient #7 was observed to be transferred to his treatment chair using a pneumatic lift. There was no documentation showing Patient #7 had been identified as unstable, due to deterioration of functional status, between 11/15/17 and 11/17/17. No reassessment had been done during that time, and there was no documentation explaining why a pneumatic lift was being used for transfers, or who had authorized the use of a lift. In an interview on 11/28/17 at 6:00 P.M., the FA was asked who was able to authorize the use of a pneumatic lift. He said "anyone" could make that change. In an interview on 12/01/17 at 9:00 A.M., the SNF charge nurse stated Patient #7 did not use a pneumatic lift for transfers at the SNF, and transferred using a one person assisted stand/pivot. The facility did not adequately assess patients for current health status and medical condition.	V 520		
V 750	CFC-GOVERNANCE CFR(s): 494.180 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	V 750	V750 Members of the Governing Body (GB) have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Conditions of Governance (V750) that are not met, as well as other standards, contain specifics of corrective plans. V750 cont on page 15	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 750	Continued From page 14 quality of clinical care received by patients at the facility. This failure resulted in patient rights violations. The findings include: 1. Refer to V751 as it relates to the facility's failure to ensure patients' rights were upheld.	V 750	V750 Continued from page 14 The Governing Body will meet weekly to ensure compliance with the POC. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi- annually. The Facility administrator	1/3/18
V 751	GOV-ID GOV BODY W/FULL AUTHORITY/RESPONS CFR(s): 494.180 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 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 personnel record review and staff interview, it was determined the facility failed to ensure the Governing Body monitored staff training related to the protection of patients' rights. This failure directly impacted 1 of 11 ICHD patients (Patients #6) whose treatments were observed or reviewed and had the potential to impact all patients receiving care at the facility. This resulted in the lack of quality patient care. The findings include: The FA identified the composition of the Governing Body as the Medical Director, the Regional Operations Director, and the Facility Administrator.	V 751	(FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC. Refer to V751 for specific plans of correction. V751 All teammates have been inserviced on patient rights, respect and dignity and on the patient assessment process. All in-services evidenced by signature sheets. All members of the Governing Body, including the FA, Medical Director, And Regional Director, will be in-serviced on the roles and responsibilities of the Governing Body by the CSS. The in-service will address all day to day operations, including the training of the facility teammates. Weekly progress of the POC will be reviewed by the governing body weekly, and is the responsibility of the FA. The CSS will audit weekly results, which will continue until 1/19/2018. Further compliance to the POC will be reviewed during monthly FHM and reported to the Governing Body no less than semi-annually. This process will be audited by the CSS for the next four months. The Governing Body is responsible for the implementation, monitoring and ongoing compliance with this Plan of correction.	1/3/18

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

PRINTED: 12/12/2017
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
	132502	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	6810 WEST GAGE STREET, SUITE B BOISE, ID 83706

(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 751	Continued From page 15 1. A review of personnel files for all staff at the facility showed documentation of annual training on clinical skills, infection control, emergency procedures, water, dialysate, and machines. No information was present showing annual staff training related to patient rights, respect and dignity, or patient assessment. 2. Refer to V450 CfC: Patient Rights and the associated standard level deficiencies as they relate to the Governing Body's failure to ensure Patient Rights were upheld. The Governing Body failed to ensure staff members were adequately trained and demonstrated the competencies necessary to uphold patients' rights and treat patients with dignity and respect.	V 751		