IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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February 1, 2018

Scott Headrick, Administrator
Table Rock Dialysis Center
5610 West Gage Street, Suite B
Boise, ID 83706

RE: Table Rock Dialysis Center, Provider #132502

Dear Mr. Headrick:

On January 24, 2018, a follow-up visit of your facility, Table Rock Dialysis Center, was conducted to verify corrections of deficiencies noted during the survey of December 4, 2017.

We were able to determine that the Medicare ESRD Conditions for Coverage of **CFC-Patients Rights (42 CFR 494.70), CFC- Governance (42 CFR 494.180)** are now met.

Also 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 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **February 12, 2018**, 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,

Dennis Kelly RN on behalf of

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

ec: 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: 01/31/2018
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 _____	R 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5910 WEST GAGE STREET, SUITE B BOISE, ID 83706

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{V 000}	INITIAL COMMENTS The following deficiencies were cited during the follow up survey at your facility from 1/22/18 - 1/24/18. The surveyors conducting the survey were: Trish O'Hara, RN, Team Lead Laura Thompson, RN Acronyms used in this report include: AMA - Against Medical Advice AVF - Arteriovenous fistula BFR - Blood flow rate BP or B/P - blood pressure CSS - Clinical Service Specialist CVC - Central Venous Catheter DFR - Dialysate flow rate d/t - due to EDW - Estimated dry weight FA - Facility Administrator FHM - Facility Health Meeting ICHD - Incenter Hemodialysis ml/min - milliliter per minute NA - Not applicable PCT - Patient Care Technician POC - Plan of Correction Pt - patient QAPI - Quality Assurance Performance Improvement Rx - Prescription s/sx - signs and symptoms TW - Target weight tx - treatment	{V 000}	V000 The Governing Body has reviewed the statement of deficiencies and plans of correction have been approved and implemented. The plan will be fully implemented by May and the completion dates represent the date that the plan was implemented and not fully executed.	3/10/18
{V 111}	IC-SANITARY ENVIRONMENT CFR(s): 494.30 The dialysis facility must provide and monitor a	{V 111}		

RECEIVED
FEB 15 2017
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matt Hedrick, RN — TITLE: FACILITY ADMINISTRATOR — (X6) DATE: 2/15/18

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 111}	Continued From page 1 sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. This STANDARD is not met as evidenced by: Based on observation, administrative document review, and staff interview, it was determined the facility failed to follow their plan of correction and implement change to correct deficiencies related to hand hygiene and infection control practices in the facility by staff. This resulted in continued failed practices which had the potential for the transmission of infection through cross contamination. Findings include: During the facility's 12/04/17 complaint survey, this standard was found out of compliance due, in part, to poor infection control practices by staff. 1. An observation of the patient treatment area was conducted on 1/23/18 beginning at 10:00 AM. During the observation, a PCT missed several opportunities for hand hygiene, as follows: - The PCT was at the chairside of a patient preparing to discontinue treatment. She removed the glove from her right hand and threw it in the trash can, walked over to an area with clean supplies and removed gauze packages and a syringe, removed a clean glove from the box and placed it on her hand while walking back to the patient chairside and proceeded with her task. She did not perform hand hygiene when removing her glove or prior to putting on the clean glove. The PCT did not remove the other glove on her left hand during this time. The PCT was observed to do the action as stated above 5 more	{V 111}	V111 A Governing Body meeting was held to discuss the exit interview findings on 1/24/18. The Governing Body recognizes the errors in execution of the plan of correction as it relates to audit and oversight. A new infection control audit was developed and implemented by the Facility Administrator (FA) with a specific focus on hand hygiene that is objectively quantifiable. This audit form focuses specifically on areas of concern as documented in the SOD during surveyor observations, and was reviewed and approved by the Governing Body (GB). Beginning the week of February 19, 2018 the Facility Infection Manager (FIM) or designee will perform infection control audits daily X2 weeks on random shifts, then weekly X4 weeks, then twice a month x 2 months. Teammates with breaches in infection control practices will be counseled at the time of observation. Continued failure to comply with policy and procedure will result in escalating disciplinary action. The audit results will be tabulated, and trends reviewed with the Governing Body (GB) weekly for four weeks as evidenced by signature sheets and/or e-mails (if done remotely), and in monthly QAPI/ Facility Health Meetings (FHM) with the Medical Director until completion of POC. Once completed, the facility will return to current process of comprehensive monthly infection control audits, reviewed in monthly QAPI/FHM meetings. The Governing Body will continue to provide oversight for plan of correction completion and sustainability monthly following the four week review. The FA as an agent for the GB is responsible for the V111 cont on page 3	3/10/18

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{V 111}	Continued From page 2 times with the same patient. - The same PCT was again observed at the chairside of another patient performing a task. She removed the glove from her right hand and walked over to the clean supply area, obtained clean supplies and a clean glove, then went back to the patient chairside and put the clean glove on and proceeded with her task. The PCT did not perform hand hygiene when removing her glove or prior to placing a new glove on her hand. 2. The facility submitted a Credible Allegation of Compliance/Plan of Correction, dated 12/21/17, which stated "Beginning the week of December 18, 2017 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." The Plan of Correction further stated "The infection control audit will be reviewed with the Medical Director at the QAPI/FHM every month." The facility alleged compliance with the submitted Plan of Correction as of 1/03/18. The Plan of Correction was not followed. Infection Control audits were requested for review and were received on 1/22/18. A total of 13 audit forms were reviewed, dated 1/04/18 through 1/20/18, after the alleged date of compliance. Of the 13 reviewed, 7 were signed by the Medical Director. During an interview at 3:10 PM on 1/23/18, the FA confirmed not all audit forms were signed by the Medical Director. When asked whether the audits were included in the QAPI meeting he stated there had not been a meeting since the	{V 111}	V111 Continued from page 2 implementation, monitoring and ongoing sustainability of this plan of correction. A Unit meeting was be held on February 13, 2018 for all clinical staff to review the most recent Statement of Deficiencies (SOD) (dated 2/1/18) as a result of the follow-up survey. The details of the Plan of Correction (POC) were reviewed, including the observations documented by the state surveyors. In-service to be provided to all clinical teammates on Policy 1-05-01 "Infection Control for Dialysis Facilities" by facility preceptor(s) at a unit meeting on February 13th, 2018 with specific a focus on hand hygiene. The unit meeting, as well as any additional in-services will be evidenced by signature sheet(s). Teammates were made aware of the infection control audit expectation and ramifications of failure to comply.	3/10/18

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{V 111}	Continued From page 3 Plan of Correction was implemented. The FA was informed regarding the observations which had taken place in the morning and the missed hand hygiene opportunities. He stated he had educated and trained staff repeatedly regarding hand hygiene and the facility's policy. The facility did not follow their Plan to Correction related to deficient practices in infection control.	{V 111}		
V 628	QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS CFR(s): 494.110(a)(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Based on Post Treatment Report Audit review, flowsheet review, and staff interview, it was determined the facility failed to ensure all facility patient outcomes were evaluated, and data collected was accurate. This failure resulted in the inability to identify problem indicators, and the inability to devise an effective action plan to correct the problem indicators. This failure directly impacted 19 of 21 ICHD patients (Patients #1, #7, and #10 - #26) whose treatment audits were reviewed, and had the potential to impact all patients receiving care at the facility. The findings include: The facility's Plan of Correction, submitted 12/21/17, stated "The FA or designee will	V 628	V628 A Governing Body meeting was held to discuss the exit interview findings on 1/24/18. The Governing Body recognizes the errors in execution of the plan of correction as it relates to audit and oversight. A new post-treatment audit was be created by the FA that was implemented to ensure that patients receive treatments as prescribed, and/or that appropriate documentation exists if there are deviations from prescription. This audit form was approved by the GB. Quality indicators identified by the audit will include, but not be limited to: treatment run time, blood flow rates, dialysate flow rates, and medications given during treatment. These audits will be performed by the FA or trained designee. Documented counseling will take place for any deviances from prescribed treatment found on the audit, and will be evidenced by signatures of both the auditor and PCT on each audit form. Continued failure to comply with policy and procedure will result in escalating disciplinary action. Beginning 2/26/2018 50% of patient's flowsheets will be audited using the new post treatment audit form for two weeks, then 25% of patients for the next six weeks. V628 cont on page 5	3/10/18

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V 628	Continued From page 4 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." 1. In an interview on 1/23/18 at 3:10 PM, the FA stated staff performed self audits, using a tool developed by a former FA. The Post Treatment Report Audit (flowsheet review) included 18 items for review. Possible answers to the items audited included only Yes or No. In an interview on 1/23/18 at 3:10 PM, the FA stated he compiled data from the audits by counting the number of Yes and No answers. He stated he used the compiled data to determine performance improvement, and the data was presented to the Governing Body as well as the QAPI committee. However, several items on the audit form asked two questions that were conflicting, with both Yes and No answers being possibly correct. These items included, but were not limited to the following: - Item # 2 stated "Treatment run time matches order or justification & follow up noted." A Yes answer could indicate either treatment time was completed as ordered, or treatment time was not completed as ordered but justification was noted. - Item #3 stated "Dialysate Flow is followed, If not followed, rationale & interventions & results documented."	V 628	V628 continued from page 4 The results will be reviewed in monthly QAPI/ FHM meetings with the Medical Director in March and April. Beginning 5/1/2018 the facility will return to current medical record audit process of 10% of patient's flowsheets each month, which are reviewed in QAPI/FHM meetings. The Governing Body will continue to provide oversight for plan of correction completion and sustainability monthly following the four week review. The FA as an agent for the GB is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/10/18

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V 628	Continued From page 5 A Yes answer could indicate the DFR was administered as ordered, or the DFR was not administered as ordered but rationale and interventions were noted. - Item #4 stated "Rx BFR is followed, if not followed, rationale & interventions & results documented." A Yes answer could indicate BFR was administered as ordered, or BFR was not administered as ordered but rationale and interventions were noted. - Item #8 stated "BP <90 or >180 has additional notes. Large BP changes have notes." The terms "additional notes" and "large BP changes" were not defined. - Item #15 stated "Is post wt is [sic] +/- 0.5 kg from target or EDW, then additional documentation is present to explain why this happened and what was done to follow up." A Yes answer could indicate EDW was attained, or EDW was not attained but an explanation was noted. 2. Audits and flowsheets were reviewed for the dates of 1/09/18, 1/11/18, 1/13/18, and 1/16/18. Exceptions noted on original flowsheets, but not noted on audit, included, but were not limited to, the following: - Patient #13 dialyzed on 1/16/18. His dialysis prescription included a BFR of 400 ml/min. His flowsheet showed a BFR of 450 ml/min during the first 2.5 hours of his 4 hour treatment. No explanation was documented. However, the	V 628		

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V 628	Continued From page 6 audit documented a Yes answer to item #4. - Patient #14 dialyzed on 1/16/18. His flowsheet showed 5 blood pressures with diastolic readings greater than 180, with no intervention by nursing. However, the audit documented a Yes answer to item #8. - Patient #10 dialyzed on 1/16/18. His flowsheet showed treatment was ended 28 minutes early due to machine failure. However, the audit documented a Yes answer to item #2. Additionally, an AMA form was completed stating "I, [patient's name] request to terminate my dialysis treatment prior to the prescribed time..." The AMA form was not signed by the patient. - Patient #11 dialyzed on 1/16/18. Her flowsheet documented a treatment time of 231 minutes. Her prescribed treatment time was 240 minutes. A nursing note stated "Pt on late d/t previous issues at the clinic." However, the audit showed a Yes answer to item #2. Item #10 stated "Vascular access care assessment noted at start of tx and end of tx." - Patient #15 dialyzed on 1/16/18. Her flowsheet indicated she had two vascular accesses, a CVC, and a developing AVF. The audit documented NA to item #10. Item #7 stated "Time Heparin infusion was started end and stopped is documented." - Patient #12 dialyzed on 1/16/18. His flowsheet showed a prescribed Heparin infusion rate of 500 units/hour. and a total infusion for the treatment	V 628		

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V 628	Continued From page 7 of 1500 units. Infusion start time was noted at 7:02 A.M. and stopped at 10:04 A.M. However, the audit documented NA to item #7. Six of six flowsheets (100%), reviewed for 1/16/18, documented exceptions not noted on audit. - Patient #1 dialyzed on 1/09/18. His systolic BP was 204 - 220 for the entire 4 hour treatment with no intervention by nursing. An additional note stated "Hypertensive since start of tx. Pt denies any s/sx of high B/P. Will monitor." Audit documented a Yes answer to item #8. - Patient #16 dialyzed on 1/09/18. Her prescribed dialysis time was 240 minutes. Her documented treatment time was 232 minutes. The RN noted the treatment was shortened for "BP support." However, the audit documented a Yes answer to item #2. - Patient #17 dialyzed on 1/09/18. His prescribed treatment time was 240 minutes. His documented treatment time was 234 minutes with no explanation noted. However, the audit documented a Yes answer to item #2. - Patient #16 dialyzed on 1/09/18. His prescribed EDW was 62.5 kg. His post weight was 63.9 kg, 1.4 kg over EDW. No extra treatment was offered and a technician's post treatment note stated only "1.4 over TW. RN and provider aware." However, the audit documented a Yes answer to item #15. Five of six flowsheets (83%), reviewed for 1/09/18, documented exceptions not noted on audit.	V 628		

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V 628	Continued From page 8 Additionally, 6 of 12 flowsheets (50%), reviewed for 1/11/18, and 9 of 15 flowsheets (60%), reviewed for 1/13/18, documented exceptions not noted on audit. Review of 41 flowsheets showed 28 flowsheets (63%) reflected inaccurate data collection. In an interview on 1/23/18 at 3:10 PM, the FA agreed the audit items could be misleading, resulting in collection of inaccurate data. It was not clear how data, related to specific quality indicators, could be accurately compiled from the audit that allowed only Yes/No answers to the probes. The facility failed to collect accurate data on which to base corrective action plans.	V 628		
V 638	QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE CFR(s): 494.110(b) The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Based on review of audits and staff interview, it was determined the facility failed to ensure the submitted Plan of Correction was monitored by the QAPI committee. This failure prevented improvements in quality of care for all patients dialyzing at the facility. Findings include:	V 638	V638 A Governing Body meeting was held to discuss the exit interview findings on 1/24/18. The Governing Body recognizes the errors in execution of the plan of correction as it relates to audit and oversight. A QAPI/FHM meeting is scheduled for February 26th, 2018 to review, among other topics, the Plan of correction, compliance audit results, and clinical outcomes from January 2018. Findings from the follow-up visit by Idaho Health and Welfare and the plan of correction, will be reviewed by all members of the IDT. The new POC will be reviewed at this time, as well as the progress of this POC, including aggregated results from both the infection control and post-treatment audits up to and including the results of the week prior. V638 cont on page 10	3/10/18

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V 638	Continued From page 9 During the facility's 12/04/17 complaint survey, standard level deficiencies were cited related to poor infection control practices by staff and patients not receiving services as outlined in their plan of care. The facility submitted a Credible Allegation of Compliance/Plan of Correction, dated 12/21/17, which stated the FA was responsible for the implementation, monitoring, and ongoing compliance with the plan. The facility alleged compliance as of 1/03/18. As part of the facility's plan for improvement they were to conduct audits for infection control practices and audits of patient records to ensure the treatment plan of care was followed. The Plan of Correction stated audits were to be reviewed during the facility's monthly QAPI meeting. The FA was interviewed on 1/23/18 beginning at 3:10 PM. He stated the monthly QAPI/FHM meeting was scheduled for 1/22/18. However, due to the follow-up survey the meeting was canceled. The FA confirmed audit information was to be presented at the meeting. However, he stated he was "not prepared" for the meeting on 1/22/18. He stated he had planned to prepare for the meeting on the morning of 1/22/18. When asked for aggregation and interpretation of the audit data the FA stated he did not have this documentation. The facility failed to develop documentation showing improvement, trends, or regression.	V 638	V638 Continued from page 9 The progress of the POC will continue to be reviewed in QAPI/FHM Meetings until the POC is completed and sustainability is determined to be complete. The details of the FHMs will be evidenced by signature sheets, and the FHR. The Governing Body will continue to provide oversight for the QAPI/ FHM process and the plan of correction to ensure completion and sustainability monthly following the four week review. The FA as an agent for the GB is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/10/18
(V 751)	GOV-ID GOV BODY W/FULL AUTHORITY/RESPONS CFR(s): 494.180	(V 751)		

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	132502	A. BUILDING _____ B. WING _____	R 01/24/2018

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(V 751)	Continued From page 10 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 evidanced by: Based on administrative document review, meeting minutes review, and staff interview, it was determined the facility failed to ensure the Governing Body followed and had oversight for compliance with the Credible Allegation of Compliance/Plan of Correction submitted to address and correct cited deficiencies from a previous survey. This resulted in repeat citations for standard level deficiencies and had the potential to effect the health and safety of patients. Findings include: During the facility's 12/04/17 complaint survey, the Condition for Coverage: Governance (V750) was found out of compliance. The facility submitted a Credible Allegation of Compliance/Plan of Correction, dated 12/21/17, which stated "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 1/19/18. Further compliance to the POC will be reviewed during monthly FHM and reported to the Governing Body no less than semi-annually ... The Governing Body [sic] is responsible for the implementation, monitoring, and ongoing compliance with this Plan of correction [sic]." The	(V 751)	V751 A Governing Body meeting was held to discuss the exit interview findings on 1/24/18. The Governing Body recognizes the errors in execution of the plan of correction as it relates to audit and oversight. All members of the Governing Body, including the FA, Medical Director, And Regional Director, will meet during the week of 2/12/2018 to review the details of the original SOD from the survey ending 12/4/2017, as well as the resulting POC. The deviations found during the follow-up to this survey as documented on the most recent SOD dated February 1st, 2018 will be reviewed in detail to ensure the new POC is followed appropriately. The revised audit tools as part of the new POC were reviewed and approved by theGB. The Regional Operations Director and Director of Clinical Services will review the GB template format to ensure that the POC is thoroughly reviewed, audit progress is trended and that plans of correction are implemented as needed to ensure the ongoing compliance with the POC and sustainability of the POC. Beginning the week of 2/26/2018 the progress of the POC (including aggregated data from the infection control, and post treatment audit tools) will be reviewed by the governing body weekly for four weeks, then monthly until sustainability is achieved. . The Governing Body will continue to provide oversight for the QAPI/FHM process and the plan of correction to ensure completion and sustainability monthly following the four week review. The FA as an agent for the GB is responsible for the implementation, monitoring and ongoing sustainability of this plan of correction.	3/10/18

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{V 751}	Continued From page 11 facility alleged compliance as of 1/03/18. However, a follow up survey was conducted from 1/22/18 to 1/24/18. At that time, the facility's Credible Allegation of Compliance/Plan of Correction was not comprehensively monitored by the Governing Body to ensure compliance was achieved and sustained. Refer to V111 and V638, standard level deficiencies as they relate to providing a sanitary environment and monitoring performance improvement through QAPI. Examples include: Governing Body meeting minutes were requested for review and were received on 1/23/18. The meeting minutes reviewed were dated 12/12/17, 12/21/17, 12/28/17, 1/03/18, 1/09/18, and 1/16/18. The meeting minutes, dated 12/12/17, documented receipt of the findings report from the complaint survey. At the 12/21/17 meeting, the minutes documented the Credible Allegation of Compliance/Plan of Correction was submitted. There was no documentation in the minutes related to a plan or implementation of changes which were taken to correct the cited deficiencies. Meeting minutes, dated 12/28/17 and 1/03/18, documented "The Governing Body convened to review the ongoing progress of the Plan of Correction submitted to the Idaho Department of Health and Welfare ..." There was no documentation in the minutes of what was reviewed or whether there was progress or improvement related to the plan of correction. The FA and CSS were interviewed together on 1/22/18 beginning at 4:10 PM. The FA stated during the meetings of the Governing Body the members discussed the audit results for infection	{V 751}		

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(V 751)	Continued From page 12 control and patient treatment records, the impact of the plan of correction, and the promotion for ongoing adherence by staff. He stated they also discussed any trends which were identified from the audits. He confirmed these discussions were not documented in the meeting minutes. The CSS stated there was an email from the FA, to herself and other members of the Governing Body, which included an outline of everything discussed in the meetings. The email was presented for review. The email was dated 1/10/18, 7 days after the date of alleged compliance, and included documentation, as follows: - "GB [Governing Body] held 1/4/18. Received approval for 'Hoyer Transfer Guidelines.'" - "Staff meeting held 1/4/18. Details of Unit Meeting evidenced by Power Point slides detailing survey results, and signature sheets." - "V111 In-servicing complete. IC [Infection Control] audits continue daily this week. Results shared in our Unit Meeting, as well as in daily Home Room meetings. These results are being shared in GB meetings, evidenced by signature sheets. Forming a more recognizable trend in improvement." - "V751 - In-servicing completed by [CSS] on 1/4/18. CSS has reviewed evidence binder." There was no documentation regarding what in-services were about or what type of education or training was included. Additionally, there was no information about the audit results and how they showed a trend in improvement or where	(V 751)		

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{V 751}	Continued From page 13 improvement had occurred. During the above interview, the CSS stated she had reviewed the Infection Control and patient record audits. She confirmed there was no documentation of the content of the inservice. The FA and the CSS stated trends were identified from audits. However, they both confirmed there was no documentation in the Governing Body meeting minutes that a trend was identified or there was improvement in the deficiencies previously cited. The Governing Body did not have oversight of the implementation of the plan of correction and failed to ensure the facility complied with the plan of correction.	{V 751}		