IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON– Director

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DIVISION OF LICENSING & CERTIFICATION
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March 16, 2018

Greg Stokes, Administrator
Liberty Dialysis Meridian
3525 E Louise Dr, Suite 100
Meridian, ID 83642

RE: Liberty Dialysis Meridian, Provider #132512

Dear Mr. Stokes:

Based on the survey completed at Liberty Dialysis Meridian, on March 7, 2018, by our staff, we have determined Liberty Dialysis Meridian is out of compliance with the Medicare ESRD Condition for Coverage of **CFC-Care at Home (42 CFR 494.100)**. 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 this condition to be unmet, substantially limit the capacity of Liberty Dialysis Meridian, 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 aehieved and eompliance verified by this office, before April 21, 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 April 9, 2018.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **March 29, 2018**.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	03/07/2018

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LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

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V 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey at your facility from 2/26/18 - 3/06/18. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AMA - Against Medical Advice BFR - Blood Flow Rate bp - blood pressure C&S - Culture and Sensitivity CM - Clinic Manager CVC - Central Venous Catheter DFR - Dialysate Flow Rate DO - Director of Operations EDW - Estimated Dry Weight G - Gram HT - Home Therapies HTPM - Home Therapies Program Manager ICHD - Incenter Hemodialysis IDT - Interdisciplinary Team IP - Intraperitoneal kg - kilogram LPN - Licensed Practical Nurse LTC - Long Term Care MAR - Medication Administration Record mcg - microgram MD - Medical Doctor mg - milligram ml/min - milliliters per minute mm Hg - millimeters of mercury ns - normal saline PD - Peritoneal Dialysis PO - Per Os (orally) PPE - Personal Protective Equipment PRN - As needed	V 000	RECEIVED MAR 27 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director of Operations	3/22/18

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 000	Continued From page 1 RN - Registered Nurse QAI - Quality Assessment and Improvement QAPI - Quality Assurance Performance Improvement SNF - Skilled Nursing Facility UF - Ultrafiltration The facility was notified of an immediate jeopardy at V 582 on 2/27/18 at 3:35 P.M. A plan of correction was submitted and accepted on 2/27/18 at 4:30 P.M. Verification of the plan's implementation was completed on 3/1/18 at 7:00 P.M., and the immediate jeopardy was removed.	V 000		
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, 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 4 of 9 ICHD patients (Patients #4, #7, #10 and #11) whose treatment records were reviewed. This resulted in blood flow rates not being delivered as ordered, placing the patients at risk for decreased adequacy and access complications. Findings include: 1. Patient #4 was a 51 year old male. Nine treatment sheets were reviewed from 2/1/18 - 2/24/18. The treatment sheets documented his prescribed BFR as 400 ml/min. One treatment	V 463		

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V 463	Continued From page 2 sheet, dated 2/15/18, documented Patient #4's BFR as 375 ml/min. No reason for the decreased BFR was noted. 2. Patient #7 was a 49 year old male. Thirteen treatment sheets were reviewed from 1/27/18 -2/24/18. The treatment sheets documented his prescribed BFR as 450 ml/min. Patient #7's treatment sheet, dated 2/06/18, showed his BFR as 400 ml/min for 3.25 hours of his 4.25 hour treatment. No reason for the decreased BFR was documented. Again, on 2/24/18, Patient #7's BFR was documented as 400 ml/min during the last 1.25 hours of his 4.25 hour treatment. No reason for the decreased BFR was documented. 3. Patient #10 was a 24 year old male. Thirteen treatment sheets were reviewed from 1/26/18 - 2/23/18. The treatment sheets documented his prescribed BFR as 450 ml/min. - On 1/26/18 his average BFR was documented as 400 ml/min. - On 2/16/18 his average BFR was documented as 470 ml/min. - On 2/19/18 his average BFR was documented as 460 ml/min. No reasons for the BFR variances were noted. 4. Patient #11 was an 81 year old female. Thirteen treatment sheets were reviewed from 1/27/18 - 2/24/18. The treatment sheets documented her prescribed BFR as 450 ml/min. - On 1/30/18 her average BFR was documented as 400 ml/min.	V 463		

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V 463	Continued From page 3 - On 2/20/18 her average BFR was documented as 400 ml/min. - On 2/24/18 her average BFR was documented as 400 ml/min. No reason for the decreased BFR was documented. In an interview on 3/5/18 at 9:00 A.M., the charge nurse confirmed the incorrect BFRs, and lack of documented reasons for the variances, for Patients #4, #7, #10, and #11. The facility failed to deliver treatments as prescribed for four patients.	V 463		
V 543	POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1) The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on standing order review, policy review, staff interview, and clinical record review, it was determined the facility failed to ensure episodes of hypertension and hypotension were addressed and that patients' fluid was managed during each treatment for 6 of 9 ICHD patients (Patients #4, #5, #7, #8, #10, and #12) whose treatment records were reviewed. This resulted in the potential for patients to experience complications due to fluid overload between dialysis treatments and complications from hypertension and hypotension. Findings include:	V 543		

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V 543	Continued From page 4 1. A document titled Initial Hemodialysis Physician Orders for Hemodialysis, undated, was included in all patient charts and referred to, by the charge nurse in an interview on 3/5/18 at 9:00 A.M., as "standing orders." a. The standing orders addressed hypertension as follows: i. Standing order #13 stated "Clonidine (an antihypertensive medication) 0.1 mg PO x 1 PRN systolic hypertension >180" and standing order #12 stated "For systolic .180 mm Hg, chart hypertension and assess for symptoms [sic]." This intervention was not implemented as follows: - Patient #12 was a 55 year old male. During his first treatment, on 2/22/18, his systolic blood pressure reading was >180 during 7 of 8 measurements. The values were 189, 194, 188, 186, 187, 187, and 189. There was no documentation of hypertension, or an assessment, or a PRN dose of Clonidine 0.1 mg. Again, during treatment on 2/24/18, Patient #12's systolic blood pressure reading was > than 180 during 7 of 8 measurements. The systolic readings were 182, 188, 192, 206, 192, 205, and 198. There was no documentation of hypertension, or an assessment, or a PRN dose of Clonidine 0.1 mg. - Patient #4 was a 51 year old male. During treatment, on 2/01/18, his systolic blood pressure reading was >180 during 3 of 7 measurements. The systolic readings were 219, 183, and 181. There was no documentation of hypertension, or an assessment, or a PRN dose of Clonidine 0.1 mg.	V 543		

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V 543	Continued From page 5 ii. Standing order #12 stated "Notify MD if post sitting systolic blood pressure is 180 mm Hf [sic]." This intervention was not implemented as follows: - Patient #12's post sitting systolic blood pressure was documented as 189, on a treatment sheet dated 2/22/18, with no documented physician notification. Again, on 2/24/18, Patient #12's post sitting systolic blood pressure reading was documented as 194 with no documented physician notification. b. The standing orders addressed hypotension as follows: i. Standing order #12 gave directions to chart hypotension and either slow fluid removal, or give fluid bolus, for systolic blood pressure <100. - Patient #8 was a 31 year old male. His treatment sheet, for 1/27/18 at 1:36 P.M., documented a systolic blood pressure of 100. A nursing note stated "reduced UF goal, monitoring BP every 10 min." No further blood pressure was documented until 2:10 P.M., 34 minutes later. Additionally, Patient #8's treatment sheet, for 2/03/18, documented his blood pressure as 87/44 at 1:38 P.M. A nursing note at 1:43 P.M. stated "UF minimum, 150 ml ns given, Bp checks set for every 5 min until bp improves." No further blood pressures were documented until 2:09 P.M., 26 minutes later. - Patient #12 was a 55 year old male. His second ever dialysis treatment sheet, dated 2/24/18, showed the patient had requested his fluid	V 543		

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V 543	Continued From page 6	V 543		

removal goal be challenged. A nursing note at 12:26 P.M. stating "pt requested 4000 ml. bp checks set for every 15 min." Blood pressures were recorded over the next 3 hours of treatment at intervals of 36 minutes, 28 minutes, 44 minutes, 47 minutes, and 35 minutes."

In an interview on 3/5/18 at 9:00 A.M., the charge nurse confirmed the unaddressed episodes of hypertension and lack of documented follow up for hypotension.

2. A policy titled Nursing Supervision and Delegation, dated 9/25/13, stated "Prior to discharge the RN must review the treatment record..." The policy delineated what should be included in the RN review. The review was to include "Whether patient is achieving dry weight (and if not, why?)".

The policy included criteria for referring a patient to the charge nurse for further assessment. Referral criteria included "Any post treatment weight with a variance from the estimated dry weight of .5 kg."

The policy also stated "The staff member who collects information pre, post and during treatment will document their findings."

This policy was not implemented, and patients were discharged significantly above their EDWs, with no documentation of referral or intervention, as follows:

- Patient #4 was a 51 year old male whose prescribed EDW was 82.5 kg. A review of 9 treatment sheets from 1/27/18 - 2/24/18 showed his post dialysis weight exceeded his prescribed

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V 543	Continued From page 7 EDW by .5 kg or more for 6 of 9 treatments, by 1.7 kg on 2/1/18, .9 kg on 2/3/18, .7 kg on 2/15/18, 1.2 kg on 2/17/18, 1.5 kg on 2/20/18, .7 kg on 2/22/18, and 2.9 kg on 2/24/18. - Patient #5 was a 46 year old female whose prescribed EDW was 48 kg. A review of 13 treatment sheets from 1/26/18 - 2/23/18 showed her post dialysis weight exceeded her prescribed EDW by .5 kg or more for 3 of 13 treatments, by 1.3 kg on 2/9/18, 1.5 kg on 2/14/18, and 1.1 kg on 2/19/18. - Patient #7 was a 49 year old male whose prescribed EDW was 86.5 kg. A review of 13 treatment sheets from 1/27/18 - 2/24/18 showed his post dialysis weight exceeded his prescribed EDW by .5 kg or more for 9 of 13 treatments, by 2.6 kg on 1/30/18, 1.5 kg on 2/01/18, 2.2 kg on 2/03/18, 2.6 kg on 2/06/18, .6 kg on 2/08/18, .8 kg on 2/10/18, 2.4 kg on 2/13/18, 1.2 kg on 2/17/18, and 2.0 kg on 2/20/18. - Patient #8 was a 31 year old male whose prescribed EDW was 46.5 kg. A review of 13 treatment sheets from 1/27/18 - 2/24/18 showed his post dialysis weight exceeded his prescribed EDW by .5 kg or more for 4 of 13 treatments, by 1.7 kg on 1/30/18, 1.5 kg on 2/01/18, 1.6 kg on 2/03/18, and 1.8 kg on 2/08/18. - Patient #10 was a 24 year old male whose prescribed EDW was 64.5 kg. A review of 13 treatment sheets from 1/26/18 - 2/23/18 showed his post dialysis weight exceeded his prescribed EDW by .5 kg or more for 11 of 13 treatments, by 1.1 kg on 1/29/18, .6 kg on 1/31/18, .7 kg on 2/05/18, .9 kg on 2/07/18, .7 kg on 2/09/18, 1.5 kg on 2/12/18, .7 kg on 2/14/18, .9 kg on 2/16/18,	V 543		

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V 543	Continued From page 8 1.2 kg on 2/19/18, 2.0 kg on 2/21/18, and 1.7 kg on 2/23/18. In an interview on 3/5/18 at 9:00 A.M., the charge nurse confirmed the documentation on treatment sheets reviewed. In an interview on 3/5/18 at 1:30 P.M., the DO and the CM stated no criteria for post dialysis weight had been determined by the Governing Body, and discharge was left to nursing judgement. The facility failed to provide interventions for patients' hypertension and hypotension, and failed to manage patients' volume status.	V 543		
V 580	CFC-CARE AT HOME CFR(s): 494.100 This CONDITION is not met as evidenced by: Based on staff interview, review of clinical records, and QAPI meeting attendance, it was determined the facility failed to ensure adequate oversight of care and services for home dialysis patients. This impacted the health and safety of 1 of 1 PD patients residing in a SNF, and had the potential to impact all PD patients requiring the services of a SNF. This failure allowed the potential for inadequate care being provided to patients by untrained staff. Findings include: Refer to V 582 as it relates to the facility's failure to assure SNF nursing staff competencies after a patient had recurrent episodes of peritonitis.	V 580		
V 582	H-IDT OVERSEES HOME TRAINING CFR(s): 494.100(a)	V 582		

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V 582	Continued From page 9 The interdisciplinary team must oversee training of the home dialysis patient, the designated caregiver, or self-dialysis patient before the initiation of home dialysis or self-dialysis (as defined in §494.10) and when the home dialysis caregiver or home dialysis modality changes. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate oversight of care, and failed to ensure adequate caregiver training was provided for home therapy dialysis patients. This directly impacted 1 of 1 PD patients (Patient #1) residing at a SNF and had the potential to impact all PD patients receiving home training and support from the facility. This failure resulted in a patient experienced recurring peritonitis and placed her at risk of serious harm, impairment or death due to a lack of adequate care being provided. Findings include: 1. Patient #1 was a 69 year old female who resided in a SNF. The SNF staff administered her peritoneal dialysis treatments. Her medical record documented the following: a) On 8/18/17 the facility received a phone call, from the SNF, reporting Patient #1 had bloody, cloudy effluent (dialysate drained from the abdomen at the end of a dwell cycle). She was subsequently treated for peritonitis. No patient/caregiver retraining was done and no root cause analysis was conducted. On 8/18/17 the MD ordered Vancomycin 2 G and Ceftazadine 1 G to be administered IP that day.	V 582		

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V 582	Continued From page 10 On 8/23/17 the MD ordered Vancomycin 2 G to be administered IP every 5 days for 14 days and a C&S of Patient #1's PD effluent after the last dose of antibiotics. Review of Patient #1's SNF MARs for August and September 2017 showed Vancomycin 2 G was given on 8/23/17 and 9/2/17 as indicated by nurse signatures. However, there was no nurse signature for 8/28/17 indicating Vancomycin 2 G was given. Additionally, results of the post antibiotic C&S could not be found. b) On 1/07/18 Patient #1 was admitted to the hospital with abdominal pain and fever. She was subsequently treated for peritonitis with three different antibiotics. No patient/caregiver retraining was done and no root cause analysis was conducted. c) On 2/26/18 a phone call was received from the SNF reporting Patient #1 was nauseated and had cloudy effluent the prior day, 2/25/18. Treatment for peritonitis was initiated with 2 antibiotics, pending C&S results. No patient/caregiver retraining was done and no root cause analysis was initiated as of 2/27/18. During a QAI meeting, on 2/27/18, Patient #1's recurring peritonitis was addressed by the medical director. He said the patient's peritoneal dialysis catheter may need to be removed due to ongoing peritonitis episodes, resulting in her return to hemodialysis. He said the patient had no viable extremity vascular accesses, leaving her CVC dependent for hemodialysis. He also	V 582		

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V 582	Continued From page 11 said he was not sure she would survive hemodialysis. In an interview on 2/27/18 at 1:45 P.M., the HTPM said she had been at the SNF on 2/16/18 in the early afternoon. At that time she witnessed a SNF LPN setting up Patient #1's night time cycler. The LPN was not wearing a mask during the set up of the cycler. The HTPM said she told the LPN aseptic technique was necessary during cycler set up, but did no further training at the SNF. In the same interview, the HTPM stated facility protocol, for recurrent episodes of peritonitis, included retraining the patient/caregivers, as well as a home visit and a root cause analysis. She confirmed no patient/caregiver retraining had been done and no root cause analysis had been conducted in response to Patient #1's three episodes of peritonitis. A contract between the dialysis facility and the SNF, dated 10/16/15, stated the dialysis facility would provide SNF staff members with initial dialysis patient care training as well as provide "generalized training updates for LTC Caregivers on a quarterly basis." Educational documentation for SNF staff was reviewed with the HTPM on 2/27/18 at 1:45 P.M. No quarterly training was documented since 8/18/17. The LPN, observed by the HTPM on 2/16/18, did not attend the August training. Her last documented training had occurred on 5/19/17. The facility failed to provide adequate oversight of	V 582		

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	132512	A. BUILDING _____ B. WING _____	03/07/2018

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V 582	Continued From page 12 care and adequate training of caregivers for Patient #1. The facility was notified of an immediate jeopardy on 2/27/18 at 3:35 P.M. A plan of correction was submitted and accepted on 2/27/18 at 4:30 P.M. The plan stated: - SNF staff will be retrained on 2/27/18, 2/28/18 and 3/1/18. - Facility RNs will provide all dialysis care for PD patients at the SNF until retraining is completed. - Retraining will include policy review including: Policy # FMS-CS-HT-I-240-012A Peritonitis and Exit Site Infection Policy # FMS-CS-IC-155-080A PPE - Wearing masks while performing exchange will be reviewed with all staff taking care of patients. - Setting up cycler and proper procedure. Policy # FMS-CS-HT-215-040A Policy # FMS-CS-HT-I-215-040C Policy # FMS-CS-HT-I-215-030C Policy # FMS-CS-HT-I-215-030A - Patient Rights and needs will be reviewed. Staff will sign confirming these rights were discussed. Patient Rights and Responsibilities Policy # FMS-CS-IC-I-103-005A Policy # FMS-CS-HT-I-200-008A - Clarity of effluent documentation practices will be discussed with all LTC staff. - IDT will meet on 3/5/18 to update plan of care and patient stability. - Patient will be considered unstable for the following 3 months. Every 30 days patient will receive a care plan from the IDT. - HT RN staff will provide 2x weekly audits of PD exchanges to monitor proper infection control	V 582		

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V 582	Continued From page 13 practices and treatment. Frequency will continue until staff can demonstrate adherence to policy and procedure. Frequency will be established per governing body. - Group Director will provide Home Therapy Program Manager one-to-one training on Infection Control practices. - The Home Therapy Program Manager will provide invitations to LTC and encourage participation in the care plan meetings. - Contract will be reviewed with LTC on 3/15/18. Verification of the plan's implementation was completed on 3/1/18 at 7:00 P.M., and the immediate jeopardy was removed.	V 582		
V 634	QAPI-INDICATOR-MEDICAL INJURIES/ERRORS CFR(s): 494.110(a)(2)(vi) The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on observation, record review, review of adverse event reports and AMA forms, and staff interview, it was determined the facility failed to ensure accurate patient adverse event data, and AMA data, was gathered and analyzed. This failure directly impacted 5 of 9 ICHD patients (Patients #4, #5, #10, #13 and #14) whose records were reviewed, and had the potential to impact all patients in the facility. Failure to gather and analyze accurate adverse event information and AMA data significantly impeded the facility's	V 634		

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V 634	Continued From page 14 ability to develop and implement appropriate corrective action plans necessary to minimize the potential for adverse events and AMAs to re-occur. Findings include: 1. A policy titled Patient Adverse Event Reporting and Documentation, dated 1/4/12, included a list of 68 events requiring an adverse event report. The list included medication error - wrong dose, medication error - omission, and non-adherence to procedure/policy with clinical consequence. a. Patient #4 was a 51 year old male. His dialysis prescription include Heparin (an anticoagulant) to be infused for the first 3 hours of his 4 hour treatment, at a rate of 500 units/hour, for a total of 1500 units/treatment. A treatment sheet, dated 2/10/18, documented Patient #4 completed a 4 hour treatment. The treatment sheet also documented 1200 units of Heparin had been infused. b. Patient #5 was a 46 year old female. Her dialysis prescription include Heparin to be infused for the first 3 hours of her 4 hour treatment, at a rate of 500 units/hour, for a total of 1500 units/treatment. Treatment sheets dated 1/26/18, 2/02/18, and 2/07/18 documented Patient #5 completed 4 hour treatments. The three treatment sheets also documented 2000 units of Heparin had been infused during each treatment. Additionally, a treatment sheet, dated 2/09/18, documented Patient #5 completed a 2 1/2 hour treatment. A Heparin infusion rate of 500 units/hour would have resulted in a total infusion	V 634		

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V 634	Continued From page 15 of 1250 units during the 2 1/2 hours. The treatment sheet documented 2000 units of Heparin had been infused. There were no adverse event reports submitted for the four events of medication error - wrong dose. c. Patient #10 was a 24 year old male. He had a physician's order for Mircera 100 mcg to be given every 2 weeks. A treatment sheet, dated 1/31/18, documented a nursing note stating the facility had no Mircera in stock and the scheduled dose was not given. There was no adverse event report for the event of medication error - omission. Additionally, a treatment sheet, dated 2/16/18, documented Patient #10's dialysis machine was put in bypass due to a lack of bicarbonate availability in the facility. The machine remained in bypass for 16 minutes, with no dialysis taking place for Patient #10. There was no adverse event report for the loss of Patient #10's dialysis time due to machine bypass, a non-adherence to procedure/policy with clinical consequence event. d. Patient #14 was a 63 year old male. A treatment sheet, dated 2/16/18, documented Patient #14's dialysis machine was put in bypass due to a lack of bicarbonate availability in the facility. The machine remained in bypass for 16 minutes, with no dialysis taking place for Patient #14.	V 634		

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V 634	Continued From page 16 There was no adverse event report for the loss of Patient #14's dialysis time due to machine bypass, a non-adherence to procedure/policy with clinical consequence event. In an interview on 3/7/18 at 11:30 A.M., the DO confirmed the lack of adverse event reporting for Patients #4,#5, #10, and #14. The facility failed to ensure accurate information, related to adverse events was provided to the QAPI committee. 2. A policy titled Early Termination or Arriving Late for Treatment, dated 7/01/12, stated "The RN who evaluates the patient must document the rationale for early termination" and "The RN is responsible to notify the physician, and document on the AMA, or Against Medical Advice form." a. Patient #13, a 58 year old male, was observed during the initiation of his treatment on 3/2/18 at 11:30 A.M. He was visibly upset and repeatedly vocalized that he wanted to end his treatment early due to his treatment being started late. Staff told him he was started late because of "a tight turn around time" on his chair. His start time was noted on the Daily Patient Schedule as 11:15 A.M. His actual start time, recorded on the treatment sheet, was 11:35 A.M. The charge nurse had Patient #13 sign an AMA form. The form stated the reason for terminating treatment was "per pt request/personal reasons" and did not state Patient #13's treatment had been initiated late. b. Patient #5 was a 46 year old female. A treatment sheet, dated 2/09/18, stated the patient's treatment had been terminated 87	V 634		

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V 634	Continued From page 17 minutes early due to a needle infiltration. A signed AMA stated the reason for early termination was due to a clotted dialyzer. In an interview on 3/07/18 at 11:30 A.M., the CM confirmed the reasons noted on the AMA forms for Patients #13 and #5. He did not offer explanation for the conflicting information. The facility failed to ensure accurate information, related to AMA for early treatment termination, was provided to the QAPI committee.	V 634		
V 714	MD RESP-DEVELOP, REVIEW & APPROVE P&P CFR(s): 494.150(c)(1) The medical director must- (1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility; This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the Medical Director participated in the development and implementation of policies that reflected the facility's current practices related to patients' fluid management. This failure directly impacted 4 of 9 patients (Patients #4, #7, #8, and #10) whose treatment sheets were reviewed, and had the potential to impact all patients receiving hemodialysis at the facility. This failure resulted in patients' being subjected to potential complications of fluid overload. The findings include: 1. A policy was requested related to nursing	V 714		

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V 714	Continued From page 18 interventions for patients who did not attain their EDW during treatments. In an interview on 3/05/18 at 1:30 P.M., the CM stated there was no policy. In the same interview, the DO said nursing response to a patient with a post treatment weight above their prescribed EDW was left to the discretion of each nurse. Without policy direction, no interventions were implemented for patients who did not attain their prescribed EDW. In an interview on 3/05/18 at 9:00 A.M., the Medical Director said he expected patients to be offered an extra treatment if their post treatment weight was 2 kg or more above their prescribed EDW. He acknowledged there was no policy, approved by the Governing Body, related to patients' fluid management. The facility failed to ensure a policy for patients' fluid management was developed and implemented. 2. Refer to V 543 as it relates to the management of patients' volume status.	V 714		
V 726	MR-COMPLETE, ACCURATE, ACCESSIBLE CFR(s): 494.170 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.	V 726		

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V 726	Continued From page 19 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain complete, accurate treatment records. The lack of documentation indicating pertinent treatment information, as well as the condition of patients, directly impacted 3 of 9 ICHD patients (Patients #4, #5, and #10) and had the potential to impact all patients dialyzing at the facility. This failure allowed the potential for inadequate treatment being administered to patients. Findings include: 1. Patient #10 was a 24 year old male. His treatment sheet for 1/31/18 documented a nursing note stating "Mircera (an erythropoetin stimulating agent) 100 mcg rescheduled for next tx due to out of stock reasons." His next treatment sheet, dated 2/02/18, was reviewed and showed the Mircera dose was not given. No documentation was present explaining why the Mircera was not given as planned. Additionally, Patient #10's 1/31/18 treatment sheet documented a nursing note stating "left ambulatory at 0.8 kg above EDW." Patient #10's EDW was prescribed at 64.5 kg and his post weight was 65.7 kg, leaving him 1.2 kg above EDW. 2. Patient #5 was a 46 year old female. Her treatment sheet, for 2/09/18, documented nursing notes stating "Treatment discontinued without problem" and "ended early due to vn (venous needle) infiltration." An AMA, signed by the patient stated the reason for early termination of the treatment was a "clotted dialyzer." 3. Patient #4 was a 51 year old male. His	V 726		

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V 726	Continued From page 20 treatment sheet, for 2/15/18, documented machine function data for BFR, DFR, needle pressures, and UF rate was collected at the start of his treatment, at 5:45 A.M. No further machine function data was collected until 7:03 A.M., 78 minutes into his treatment. In an interview on 3/05/18 at 9:00 A.M., the charge nurse confirmed, and took notes concerning, the above noted discrepancies in documentation. In an interview on 3/7/18 at 11:30 A.M., the CM confirmed the patient treatment sheet was a permanent record and was the only documentation showing a detailed account of a patient's treatment. The facility failed to ensure complete, accurate medical records were kept for patients.	V 726		

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E 000	Initial Comments No deficiencies were cited during the recertification of your facility, from 2/26/18 - 3/06/18, for Emergency Preparedness. Liberty Dialysis - Meridian is in compliance with the requirements of CFR 494.62. The surveyor conducting the survey was: Trish O'Hara RN	E 000		

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

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.

Fresenius Medical Care

Dba Meridian Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 3/7/2018

V463

On 3/22/2018, the Facility Administrator held a staff meeting and reinforced the expectations and responsibilities of the facility staff on Policies:

- FMS-CS-IC-I-105-017A Auto flow Dialysate Policy
- FMS-CS-IC-I-105-018C Verify Auto flow Dialysate orders Procedure
- FMS-CS-IC-I-115-006A Assessment and Preparation of Internal Access for Needle Placement Policy

Education emphasis was placed on:

- Ensure Direct Patient Care staff are trained on how to program the Hemodialysis machine to match the physician orders.
- Verify Blood Flow Rate that is programmed into the Dialysis Machine is the same as the physicians order.
- Ensure direct patient care staff monitor the Blood Flow Rate with every 30 minute vital check during the patient's treatment. Notifying the Registered Nurse immediately if findings are not same as order.
- Ensure direct patient care staff document the reason the blood flow rate are not the same as the physicians order. Notify Registered Nurse.
- Registered Nurse will notify Physician or Physician extender of the finding and document orders to follow given by Physician or Physician extender.
- Ensure direct patient care staff are advancing needles per the order schedule of the physician, following the blood flow rate for each needle change of advancement.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service at a later date.

Effective 3/9/2018, Facility Administrator or designee will conduct 3 audits weekly, utilizing the Clinic Audit Checklist for Machine and Dialysate audit tool for 4 weeks. All of these audits will be structured to cover multiple shifts and multiple staff (one audit per shift, different staff members every audit) to ensure that overtime, every shift and every staff member is audited. The Governing Body will determine on-going frequency of the audits based on compliance. Once 90% compliance is sustained monitoring will be done through the Clinical Practice Checklist Audit per the Quality Assessment Improvement Calendar, 3 times a month.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

Fresenius Medical Care

Dba Meridian Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 3/7/2018

The Director of Operations is responsible to present the status of the Pan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiencies will be corrected by 4/9/2018.

Fresenius Medical Care

Dba Meridian Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 3/7/2018

V543

On 3/22/2018, the Facility Administrator held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-I-110-141 A Safety Checks Policy
- FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy
- CMS guideline for fluid removal of 13ml/kg/hr.

Education emphasis was placed on:

- Ensure all standing orders in the patient charts are dated and labeled as Standing orders.
- Ensure direct patient care staff accurately evaluate the patients' blood pressures pre-dialysis, during treatment, and post-dialysis with appropriate documentation.
- Ensure direct patient care staff identify patients with high blood pressures (hypertension) and/or low blood pressures (hypotension).
- Ensure direct patient care staff notify the Registered Nurse Team Leader(s) immediately upon identification of hypertension/hypotension in the patients in order for the RN to fully assess those patient(s).
- Ensure direct patient care staff follow direction given when taking vital signs. When increase in frequency is requested ensure documentation of increased frequency is completed.
- Ensure Registered Nurse notify the primary physicians to ensure proper intervention is accomplished to address the hypertensive/hypotensive episodes.
- Ensure Standing orders are followed as directed for episodes of hypertensive/hypotensive episodes.
- Ensure direct patient care provides Documentation of the evaluation of the patients' blood pressures must be placed in the post-dialysis assessment sections by the licensed nurses, with documentation of monitoring during the treatment entered into the Chairside computer system for inclusion on the printed treatment flow sheets.
- Ensure Post assessment notes reflect whether the patient met or not met estimated dry weight by 0.5kg prescribed by physician.
- Ensure RN to notify the physician or physician extender of the difference of the post weight from estimated dry weight.
- Ensure RN receives orders from physician or physician extender for extra treatment or other guidance for the patient.
- Ensure estimated dry weights and how frequently a patient goes out above or below them, is discussed in the Quality Assessment Improvement meeting monthly.

Fresenius Medical Care

Dba Meridian Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 3/7/2018

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered by 3/26/2018.

Effective 3/9/2018, Facility Administrator or designee will conduct 3 audits weekly, utilizing the audit tool for estimated dry weights achieved post treatment and documentation for hypertension/hypotension with intervention for 4 weeks. All of these audits will be structured to cover multiple shifts and multiple staff (one audit per shift, different staff members every audit) to ensure that over time, every shift and every staff member is audited. The Governing Body will determine on-going frequency of the audits based on compliance. Once 90% Compliance is sustained, monitoring will be done monthly treatment record audits 3 times a month. This will be covered monthly in the Quality Assessment Improvement meeting.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be corrected by 4/9/2018.

Fresenius Medical Care

Dba Meridian Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 3/7/2018

V580 494.100 CFC Care at Home Condition Statement

The Governing Body of Fresenius Kidney Care Dialysis Services Meridian Dialysis acknowledges its responsibility to ensure the provision of a peritoneal dialysis home training and support program by ensuring:

- All PD patient's education processes are evaluated and tailored to the individual needs of the home dialysis patients within a Long Term Care Facility.
- RN Nursing home staff and patients demonstrate adequate comprehension of the training for the process of PD.
- Staff audit and identify problems on the peritoneal dialysis treatment logs of the home peritoneal dialysis patients.
- Documentation that demonstrated the home peritoneal dialysis nursing home visit checklist is reviewed and signed by the physician.
- PD home therapies patients and nursing home providers are given contact information to facilitate communication between the patient and the interdisciplinary team.

The Governing Body met 3/8/2018 following the exit interview to discuss areas of potential deficiencies and began immediate corrections of these issues. Upon receiving the Statement of Deficiencies, the Governing Body reconvened to discuss the cited deficiencies and develop a plan of correction. The Governing Body has taken immediate actions to bring our facility into compliance with the conditions of coverage. The Governing Body has committed to weekly meetings starting 3/8/2018 to review progress of the plan of correction until all issues are resolved and the facility is back in compliance. Additionally, the Plan of Correction will be reviewed during the monthly QAI meeting for at least one calendar year from the date of the survey. The minutes from both the Governing Body and QAI meeting are for review in the facility.

Effective immediately:

- The Facility Administrator and Home Program Therapies Manager will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.
- A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI agenda.
- The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The Director of Operations of the Home Program will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

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Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions in addition to the Governing Body's direction, oversight and the QAI Committees ongoing monitoring of the facility's' activities. These are available for review at the facility.

The responses provided for V582 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to with sustained compliance.

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V582

On 2/27/2018 the Home Therapies Program Manager visited the Life Care facility and held a meeting with all Nursing staff to reinforce the expectations and responsibilities of the facility staff on policies:

- FMS-CS-HT-I-240-012A Peritonitis and Exit Site Infection Assessment and Treatment Policy
- FMS-CS-IC-II-155-080A Personal Protective Equipment Policy
- FMS-CS-HT-I-215-040A Baxter Home Choice/Home Choice Pro CCPD Set-up Policy
- FMS-CS-HT-I-215-040C Baxter Home Choice/Home Choice Pro CCPD Set-up Procedure
- FMS-CS-HT-I-215-030A Baxter Ultra Bag CAPD exchange Policy
- FMS-CS-HT-I-215-030C Baxter Ultra Bag CAPD exchange Procedure
- FMS-CS-IC-I-103-005A Patient Rights and Responsibilities Policy
- FMS-CS-HT-I-200-008A Home Patient Responsibilities Policy

Education emphasis was placed on:

- Ensure documentation of Quality Assessment Improvement meetings shows discussion of oversite for the patients in the Long Term Care facilities.
- Home Therapy Registered Nurse will provide exchanges to peritoneal dialysis patients at nursing home on 2/27/2018-3/1/2018, while Long Term Care Licensed Practicing Nurse/Registered Nurses are reeducated on the Fresenius Kidney Care policy and procedures.
- No Long Term Care Licensed Practicing Nurse/Registered Nurses will provide exchanges until staff are re-educated on exchanges and cycler machine set up.
- Ensure clarity of effluent documentation practices are known by Long Term Care staff.
- On 3/5/2018 Interdisciplinary Team met to update the plan of care and the patient's stability.
- Patient will be considered unstable for the following 3 months.
- Ensuring every 30 days patient will receive a care plan for the Interdisciplinary Team.
- Ensure Home Therapies Registered Nurse provides twice weekly audits of the Peritoneal Dialysis exchanges, monitoring the proper infection control practices and treatment.
- Contract with Long Term Care Facility was reviewed on 3/8/2018.

For those Nursing care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 2/28/2018.

Effective 2/28/2018, Home Program Manager or designee will conduct 2 audits weekly utilizing the audit tool, for 6 weeks. Until which time every nursing staff member is audited, and shows competency in providing Peritoneal Dialysis care. The Governing Body will determine on-going frequency of the audits based on compliance. Once 100% Compliance is sustained, monitoring will be done quarterly per contract with Long Term Care facility. This will be covered monthly in the Quality Assessment Improvement meeting.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

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The Director of Operations for Home Therapies is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be correct by 4/9/2018.

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Date of Survey: 3/7/2018

V634

On 3/22/2018, the Facility Administrator, held a staff meeting and reinforced the expectations and responsibilities of the facility staff on Policies:

- FMS-CS-IC-I-101-001A Quality Assessment and Performance Improvement Program Policy
- FMS-CS-IC-II-165-001A Patient Adverse Event Policy

Educational Emphasis was placed on staff practice:

- On 3/13/2018 Quality Assessment and Improvement Prep Education Class provided by the Regional Quality Manager and Group Director of Quality for Home Therapies.
- Learning Modules System adverse event training done for all staff, to ensure the knowledge of what is an adverse event.
- Ensure complete documentation in accordance with Quality Assessment Improvement and Adverse Even Policies is followed.
- Ensure adverse event and/or Against Medical Advice sign off is documented in patient health record.
- Ensure event has been entered into the Adverse Event Summary for Hemodialysis or Peritoneal Dialysis.
- Ensure Facility Administrator is notified of Adverse Event and/or Against Medical Advice sign off.
- Ensure the Quality Assessment and Performance Improvement Program held monthly, Reviews and evaluates each individual Adverse Event and/or Against Medical Advice sign off.
- Ensure Trending patient safety, outcome, and ways to prevent said event if applicable.
- Ensure if trend is found, Root Cause Analysis is completed, and documented in Quality Assessment Improvement.
- Ensure Action plan is created to work and update the process of the analysis and the progress of initiations.
- Ensure Governing Body minutes reflect the update of trend findings, and discussion of Quality Assessment Improvement process.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service by 3/26/2018

Effective 3/9/2018, Facility Administrator or designee will conduct Bi-weekly preparation for Quality Assessment Improvement using equip adverse event entry log tool with documentation of checking Adverse Events from Staff. Quality Assessment Improvement minutes to include a greater focus on adverse events and their outcomes for the next 6 Months. The Governing Body will determine on-going frequency of the audits based on compliance. Once 90% compliance is

sustained monitoring will be done through the equip Adverse Event entry log Audit per the Quality Assessment Improvement Calendar, on a Monthly basis.
Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Pan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be corrected by 4/9/2018.

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V714

On 3/22/2018, the Facility Administrator held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- Fluid Assessment Facts and Question's

Education emphasis was placed on:

- Section 10 of Fluid Assessment Facts and Questions: 10. Does that mean we have to contact the Medical Director because if we adjust the Target Weight we are not getting the patient to their prescribed Estimated Dry Weight? Yes, the physician will need to be notified regarding weight adjustment if this means the patient will not reach their prescribed Estimated Dry Weight.
- Governing Body meeting held on 3/8/2018, the Medical Director put into place the requirement to notify the physician or the physician extender when a patient leaves treatment greater than 1kg above their estimated dry weight to obtain further direction for the patient.
- Ensure Registered Nurses call the physician or the physician extender for a patient leaving treatment greater than 1kg higher then estimated dry weight.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on/will be delivered by 3/26/2018.

Effective 3/9/2018, the Facility Administrator and or designee will be notified and documentation verified of all patients leaving greater than 1kg ahove estimated dry weight. The Audit tool will be utilized for 4 weeks until new process has been fully adopted. The Governing Body will determine on-going frequency of the audits once 90% Compliance is sustained. This will be reported monthly in the Quality Assessment Improvement meeting monthly.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

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The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be corrected by 4/9/2018.

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V726

On 3/22/2018, the Facility Administrator, held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-150-030A Medical Record Documentation Standards

Education emphasis was placed on:

- Ensure all direct patient care staff monitor and maintain complete, accurate, and accessible records on all patients.
- Ensure a complete, separate medical record will be maintained for each patient treated at the dialysis facility.
- Ensure the dialysis record reflects the condition of the patient from the time of first dialysis treatment until the patient is discharged.
- Ensure all entries to the medical record should be made as soon as possible after an event or observation is made.
- All entries should never be made in advance.
- Ensure each entry is complete and accurate, containing all significant information.

For those staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service by 3/26/2018.

Effective 3/9/2018, Facility Administrator or designee will conduct audits of direct patient care documentation and charting of patients utilizing The Audit tool for accurate documentation 3 times a week, for a period of 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once 90% Compliance is sustained, monitoring will be done through the Medical record audits 3 times a month per the Quality Assessment Improvement monthly schedule.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

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Date of Survey: 3/7/2018

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be corrected by 4/9/2018.