IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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May 14, 2018

Linda Williams, Administrator
Yellowstone Dialysis Center
1165 Summers Drive
Rexburg, ID 83440

RE: Yellowstone Dialysis Center, Provider #132510

Dear Ms. Williams:

This is to advise you of the findings of the Medicare survey of Yellowstone Dialysis Center, which was conducted on May 9, 2018.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **May 29, 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,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132510	A. BUILDING _____ B. WING _____	05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE DIALYSIS CENTER	1165 SUMMERS DRIVE REXBURG, ID 83440

(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 Yellowstone Dialysis Center was found in compliance with the requirements of 42 CFR Part 494 Subparts A, C, and D, Conditions for Coverage of End-Stage Renal Disease Facilities during the recertification survey conducted from 4/30/18 - 5/09/18. The surveyor conducting the survey was: Trish O'Hara RN, HFS	V 000	RECEIVED MAY 22 2018 FACILITY STANDARDS	

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

Steven R. Jensen | Director | 5/18/18

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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E 000	Initial Comments The following deficiencies were cited during the initial Emergency Preparedness survey at your facility from 4/30/18 - 5/09/18. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: CCHT - Certified Clinical Hemodialysis Technician	E 000		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 494.62(b)(1) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and	E 018	1. Facility Manager will implement Exhibit 1 – Emergency Patient Roster and Exhibit 2 – Emergency Staff Roster into the Disaster Planning Binder. 2. Emergency Procedures Policy (Exhibit 5) is updated on pg 5 of 31 to address communication of patient location and status 3. Emergency Procedures Policy (Exhibit 5) is updated on pg 5 of 31 to address communication of staff location and availability to the administration	5/31/2018

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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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E 018	Continued From page 1 sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 018	4. Facility Manager will in-service the facility staff on these updates. This will be documented using the facilities in-service record and will be completed by May 31, 2018. 5. Compliance will be reviewed by Associate Director no later than June 30, 2018.	5/31/2018 6/30/2018

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E 018	Continued From page 2 *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure policies and procedures were developed and implemented for tracking staff and patients relocated during an emergency. This failure impacted 14 of 14 patients (Patients #1 - #14) who were dialyzing at the facility. Lack of a tracking process had the potential to hinder the facility's ability to provide care and continuation of services. The findings include: Review of the facility's policies and procedures included in the Disaster Planning binder, updated 10/2017, showed no documented system in place to track the location of staff and patients if relocation was necessary during an emergency. In an interview on 5/09/18 at 10:00 AM, the Clinical Manager stated the facility did not have a process for tracking relocated patients and staff. The facility failed to ensure tracking policies were in place.	E 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 494.62(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 022	1. The Emergency Procedures Policy (Exhibit 5) is updated on pg 24 of 31 to include discussion and instruction on Sheltering in Place	

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E 022	Continued From page 3 reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure policies and procedures were developed and implemented for patients and staff to shelter in place. This failure impacted 14 of 14 patients (Patients #1 - #14) who were currently dialyzing at the facility. Lack of a current policy and procedure for sheltering in place had the potential to put staff and patients' safety at risk during an emergency. The findings include: Review of facility policies and procedures, included in the facility's Disaster Planning binder, updated 10/2017, showed no policy or procedures for sheltering in place. In an interview on 5/09/18 at 10:00 AM, the Clinical Manager stated the facility did not have a policy or procedure for patients and staff to shelter in place.	E 022	2. Facility Manager will administer an in-service on Sheltering in Place. This will be documented in the facilities in-service record and completed on May 31, 2018. 3. Compliance will be reviewed by the Associate Director no later than June 30, 2018.	5/31/2018 6/30/2018

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E 022	Continued From page 4 The facility failed to ensure a policy for sheltering in place was developed and implemented.	E 022		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 494.62(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to develop and implement policies and procedures for the use of volunteers during an emergency for 14 of 14 patients (Patients #1 - #14) who dialyzed at the facility. . This failure had the potential to hinder the facility's ability to care for patients and provide continuation of care during an emergency. The	E 024	1. The Emergency Procedures Policy (Exhibit 5) is updated on pg 24 of 31 to include discussion and guidance on volunteer utilization. 2. Facility Manager will implement the Volunteer Management Log (Exhibit 4) into the Disaster Plan binder. 3. Facility Manager will in-service the facility staff on the updated Emergency Procedures Policy (Exhibit 5) to include guidance on volunteer utilization. This will be documented in the facility in-service record and completed by May 31, 2018. 4. Compliance will be reviewed by the Associate Director no later than June 30, 2018.	5/31/2018 6/30/2018

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E 024	Continued From page 5 findings include: Review of policies and procedures included in the facility's Disaster Planning binder, updated 10/2017, failed to show a current plan addressing the use of volunteers during an emergency. In an interview on 5/09/18 at 10:00 AM, the Clinical Manager stated the facility did not have a policy related to the use of volunteers in the event of an emergency. The facility failed to develop a policy addressing the use of volunteers during an emergency.	E 024		
E 033	Methods for Sharing Information CFR(s): 494.62(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of	E 033	1. The Facility Manager will implement Exhibit 1 – Emergency Patient Roster in the Disaster Planning Binder. This will be completed by May 31, 2018. 2. Emergency Procedures Policy (Exhibit 5) is updated on pg 5 of 31 to address communication of patient location and status. 3. Facility Manager will in-service the facility staff on these updates. This will be documented using the facilities in-service record and will be completed by May 31, 2018. 4. Compliance will be reviewed by Associate Director no later than June 30, 2018.	5/31/2018 5/31/2018 6/30/2018

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E 033	Continued From page 6 patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on disaster plan review and staff interview, it was determined the facility failed to ensure a comprehensive communication plan was developed to include a process for sharing patients' location and condition in the event of an emergency for 14 of 14 patients (Patients #1 - #14) who were currently dialyzing at the facility. This failure allowed the potential for a loss of continuity of care. The findings include: Review of the facility's Disaster Planning binder, updated 10/2017, showed no procedure was in place for the release of information about the location and condition of evacuated patients to family members or other authorized persons. In an interview on 5/09/18 at 10:00 AM, the Clinical Manager stated the facility did not have a procedure in place addressing the release of information concerning patients' location and condition.	E 033		

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E 033	Continued From page 7 The facility failed to ensure a comprehensive communication plan included sharing of patient information.	E 033		
E 038	ESRD EP Training Program CFR(s): 494.62(d)(1) (d)(1) Training program. The dialysis facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. Staff training must: (iii) Demonstrate staff knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. (iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and (v) Properly train its nursing staff in the use of emergency equipment and emergency drugs. (vi) Maintain documentation of the training. This STANDARD is not met as evidenced by:	E 038	1. Facility Manager will read the Emergency Procedures Policy (exhibit 5) and take the Disaster Plan Quiz (exhibit 6). This will be filed in the Facility Manager's personnel file. This will be completed by May 31, 2018. 2. Facility Manager will in-service the facility staff on the Emergency Procedures Policy (exhibit 5) which includes the disaster plan. This will be documented in the facilities in-service record and will be completed by May 31, 2018. 3. Each staff member will in turn complete the Disaster Plan quiz (exhibit 6). This will be filed in each staff members personnel file. 4. Compliance will be reviewed by the Associate Director no later than June 30, 2018	5/31/2018 5/31/2018 6/30/2018

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E 038	Continued From page 8 Based on inservice record review and staff interview, it was determined the facility failed to educate staff on emergency preparedness for 14 of 14 patients (Patients #1 - #14) who were currently dialyzing at the facility. This failure had the potential to hinder staff response during an emergency. The findings include: A review of staff inservice meeting minutes, from September 2017 - March 2018, showed no documentation of staff training related to the facility's disaster plan. In an interview on 5/03/18 at 4:30 PM, the CCHT and the charge nurse both stated they were not familiar with the Disaster Planning binder and had not received training related to the facility's emergency plan. They said they had not been involved in an actual emergency exercise at the facility. The facility failed to ensure staff were trained in emergency preparedness policies.	E 038		
E 039	EP Testing Requirements CFR(s): 494.62(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]	E 039	1. Facility Manager will complete a test of the Disaster Plan no later than May 31, 2018. This drill will include all staff and will test communication procedures with the home office as well as another facility, staff knowledge, and response to patient inquiry. This exercise will be documented in detail in the facilities in-service log book	

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E 039	Continued From page 9 (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039	2. When completed, a review of the drill will occur in a QAPI meeting with the IDT members. Discussion of this review will be documented in the QAPI minutes to be completed no later than June 30, 2018. 3. Compliance will be reviewed by the Associate Director no later than July 31, 2018.	6/30/2018 7/31/2018

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(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
E 039	Continued From page 10 (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on disaster plan review and staff interview, it was determined the facility failed to test the emergency preparedness plan for 14 of 14 patients (Patients #1 - #14) who were currently dialyzing at the facility. This failure had the potential to hinder staff and patient response during an actual emergency. The findings include: A review of the facility's Disaster Planning binder, updated 10/2017, showed no documentation related to the execution of an emergency drill. In an interview on 5/03/18 at 5:15 PM, the Clinical Manager confirmed no drills or exercises had been performed to test the emergency plan.	E 039		
E 042	Integrated EP Program CFR(s): 494.62(e) (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified	E 042	1. The Facility Manager in conjunction with the QAPI IDT members will complete the Risk Assessment Tool (Exhibit 3) no later than May 31, 2018. This tool will be filed in the Disaster Plan binder	5/31/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132510	A. BUILDING _____ B. WING _____	05/09/2018

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YELLOWSTONE DIALYSIS CENTER	1165 SUMMERS DRIVE REXBURG, ID 83440

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E 042	Continued From page 11 facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This STANDARD is not met as evidenced by: Based on disaster planning review and staff interview, it was determined the facility, a part of an integrated healthcare system, failed to ensure an individualized facility based risk assessment	E 042	2. Findings from the Risk Assessment Tool (exhibit 3) will be discussed and documented in the QAPI minutes for the May 2018 QAPI meeting. The risk analysis will include identifying higher risk hazards and discussing the ability of the current disaster plan to address these risks. 3. Compliance with this task will be reviewed by the Associate Director no later than June 30, 2018.	6/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132510	A. BUILDING _____ B. WING _____	05/09/2018

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E 042	Continued From page 12 was performed for 14 of 14 patients (Patients #1 - #14) who dialyzed at the facility. This failure prevented the facility from developing training and testing that included strategies addressing facility specific risks. The findings include: Review of the facility's Disaster Planning binder, updated 10/2017, showed no documented facility based risk assessment. In an interview on 5/01/18 at 10:00 AM, the Clinical Manager said no facility based risk assessment had been performed. The facility failed to ensure the integrated healthcare system emergency preparedness plan included a facility based risk assessment.	E 042		