IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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July 10, 2018

Amy Kovacs, Administrator
Fresenius Medical Center Hayden Lake
7600 N Mineral Drive, Suite 850
Coeur D Alene, ID 83815

RE: Fresenius Medical Center Hayden Lake, Provider #132525

Dear Ms. Kovacs:

This is to advise you of the findings of the Medicare survey of Fresenius Medical Center Hayden Lake, which was conducted on June 29, 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 **July 23, 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 for

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
	132525	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CENTER HAYDEN LAKE	7600 N MINERAL DRIVE, SUITE 850 COEUR D ALENE, ID 83815

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E 000	Initial Comments The following Emergency Preparedness deficiencies were cited during the recertification survey at your facility from 6/25/18 - 6/29/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: EP - Emergency Preparedness CfC - Condition for Coverage CM - Clinical Manager HT - Home Therayy HTPM - Home Therapy Program Manager ICHD - Incenter Hemodialysis	E 000	RECEIVED JUL 23 2018 FACILITY STANDARDS	
E 031	Emergency Officials Contact Information CFR(s): 494.62(c)(2) [(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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman.	E 031		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Clinical Manager	7/23/18

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

07/23/2018

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E 031	Continued From page 1 (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the facility failed to develop a communication plan with contact information for Federal, State, tribal, regional, and local emergency preparededness staff. This failure had the potential to hinder both internal and external emergency personnel response, and to hinder the coordination of patient care during an emergency. This deficient practice had the potential to affect all patients and staff at the facility. The findings Include: On 6/28/18 from 9:00 AM to 10:00 AM, the facility's EP plan was reviewed. The plan did not include contact information for emergency management officials. In an interview at the time of the plan review, the CM confirmed the missing contact information. The facility failed to ensure a communication plan included contact information for community emergency management officials.	E 031		
E 034	Information on Occupancy/Needs CFR(s): 494.62(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 034		8/10/18

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E 034	Continued From page 2 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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to document a current plan for sharing information related to facility needs, and ability to provide assistance, with emergency management officials. This failure had the potential to hinder response assistance and continuity of care for patients. This deficient practice had the potential to impact all staff and patients at the facility. The findings include: The facility's EP plan was reviewed on 6/28/18 from 9:00 AM - 10:00 AM. There was no documentation showing the facility had communication with emergency management	E 034		

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E 034	Continued From page 3 officials in the community to share information about the facility's needs, and the facility's ability to provide assistance, in case of emergency. In an interview, at the time of the plan review, the CM stated she had not had contact with local emergency management officials to provide information about facility needs and capabilities in the event of an emergency. The facility failed to communicate with local emergency management officials.	E 034		
E 036	EP Training and Testing CFR(s): 494.62(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at	E 036		8/10/18

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E 036	Continued From page 4 §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide current emergency preparedness testing for patients. Lack of an emergency testing program, covering the emergency preparedness plan and policies for the facility, had the potential to hinder patient response during an emergency. This deficient practice directly impacted 3 ICHD patients and 4 HT patients (Patients #1 - #7) and had the potential to impact all patients dialyzing at the facility. The findings include: Records were reviewed for Patients #1 - #7. A pamphlet, titled Preparing for Emergencies, was documented as having been provided to each patient at the time of admission. This pamphlet included emergency phone numbers, emergency diets,and instructions for disconnecting from the dialysis machine. However, the patient records did not document participation in emergency drills. In an interview on 6/25/18 at 9:00 AM, the CM confirmed the information provided. She stated	E 036		

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E 036	Continued From page 5 facility patients had not been included in an emergency drill. The facility failed to provide an emergency testing program for patients.	E 036		
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.	E 038		8/10/18

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E 038	Continued From page 6 (vi) Maintain documentation of the training. This STANDARD is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure staff were able to demonstrate knowledge of emergency procedures. This resulted in staff being unable to speak to their role in the facility's emergency preparedness plan. The findings include: PCT A was interviewed on 6/27/18 at 2:30 PM. She stated she was not aware of a new facility emergency plan and had not received recent training. The Biomed Technician was interviewed on 6/25/18 at 1:00 PM. He stated he was not aware of a new facility emergency plan and had not received recent training. The HTPM was interviewed on 6/27/18 at 9:00 AM. She stated she was not aware of a new facility emergency plan and had not received recent training. The MSW was interviewed on 6/28/18 at 11:00 AM. She stated she was not aware of a new facility emergency plan and had not received recent training. The CM was interviewed on 6/28/18 at 9:00 AM. She stated staff had not received emergency preparedness training pursuant to CfC 494.62, effective 11/15/17. The facility failed to ensure staff received training related to a regulatory compliant emergency preparedness plan.	E 038		
E 039	EP Testing Requirements	E 039		8/10/18

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E 039	Continued From page 7 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:] (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	E 039		

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E 039	Continued From page 8 [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. (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 EP plan review, and staff interview, it was determined the facility failed to ensure the participation in two full scale or table top exercises, designed to test the effectiveness of the emergency plan. Lack of training to a simulated event, utilizing the components of the emergency preparedness plan and policies for the facility, had the potential to hinder staff and patient response during a disaster. This deficient practice affected all staff and patients at the facility. The findings include: The facility's EP plan was reviewed on 6/28/18 at 9:00 AM. There were no full scale or table top exercises documented. PCT A was interviewed on 6/27/18 at 2:30 PM. She stated she was not aware of a new facility emergency plan and had not participated in an	E 039		

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E 039	Continued From page 9 exercise/drill. The Biomed Technician was interviewed on 6/25/18 at 1:00 PM. He stated he was not aware of a new facility emergency plan and had not participated in an exercise/drill. The HTPM was interviewed on 6/27/18 at 9:00 AM. She stated she was not aware of a new facility emergency plan and had not participated in an exercise/drill. The MSW was interviewed on 6/28/18 at 11:00 AM. She stated she was not aware of a new facility emergency plan and had not participated in an exercise/drill. In an interview, at the time of the plan review, the CM stated there had been no full scale or table top exercises at the facility. The facility failed to test the EP plan.	E 039		

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V 000	INITIAL COMMENTS [CORE] The following deficiency was cited during the recertification survey at your facility from 6/25/18 - 6/29/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: ATOM - Area Technical Operations Manager PM - Preventive Maintenance	V 000		
V 403	PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU CFR(s): 494.60(b) The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on staff interview, equipment log review, policy review, and manufacturer's recommendation review, it was determined the facility failed to ensure dialysis machines were maintained in accordance with the manufacturer's recommendations for 2 of 14 machines (machines #5951 and #5864) used at the facility. This failure had the potential to impact all patients at the facility by receiving dialysis treatments with potentially faulty equipment. Findings include: The facility used 14 Fresenius 2008T dialysis machines to perform hemodialysis treatments for	V 403	RECEIVED JUL 23 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew Lewis — TITLE: Director of Operations — (X6) DATE: 7-23-18

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FRESENIUS MEDICAL CENTER HAYDEN LAKE	7600 N MINERAL DRIVE, SUITE 850 COEUR D ALENE, ID 83815

(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 403	Continued From page 1 18 patients. Facility Policy titled Fresenius Criteria for Preventive Maintenance (#153-060-010), dated 7/15/1994, stated all dialysis equipment maintenance "will be in accordance with the manufacturer's printed recommendations." The undated maintenance manual for Fresenius 2008T machines, Part 508033 Revision F, stated a 6 month/semi annual PM procedure should be performed "every 6 months of machine operation." The manual also stated an annual PM procedure should be performed "every 12 months or 4000 hours of operation, whichever comes first." The facility machine maintenance logs were reviewed. Documentation of PM could not be found, as follows: Machine #5951 did not have documentation of 6 month/semi annual PM, which was due in December 2017. Machine #5864 did not have documentation of an annual PM, which was due in February 2018. In an interview on 6/26/18 at 9:30 AM, the facility's ATOM confirmed the missing PM documentation. He stated the facility's electronic system, used for tracking machine maintenance, sent a reminder of maintenance due at the beginning of each month. Documentation of the reminder information for the months of December, 2017 and February, 2018 could not be located. The ATOM was unable to explain why the scheduled maintenance had been missed.	V 403		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132525	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CENTER HAYDEN LAKE	7600 N MINERAL DRIVE, SUITE 850 COEUR D ALENE, ID 83815

(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 403	Continued From page 2 The facility failed to ensure hemodialysis machines were maintained according to manufacturer's recommendation.	V 403		

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V403

On 7/2/2018 the Area Technical Operations Manager held a staff meeting with the Biomed technical staff and reinforced the expectations and responsibilities of the facility on Policies:

- 153-060-010 Preventive maintenance
- 153-060-020 Equipment Repair Records
- 2008T Machines Operating Manual

Infection Control Overview Emphasis was placed on:

- Hemodialysis machines will be maintained according to manufacturer's recommendation.
- Hemodialysis machines will have 1 semi-annual, and 1 annual preventative maintenance which includes electrical testing done each year.
- Area Technical Operations Manager and Biomed Technician devised a machine preventative schedule for the year for all machines.
- Ensure machines on the machine preventative schedule for the month are completed timely.
- On 6/26/2018 the 2 machines in question during survey had an annual preventative maintenance and electrical testing completed.

Effective 7/1/2018, Area Technical Manager or Biomed designee will conduct a monthly audit utilizing the Biomed Discussion points for the Preventative Maintenance of the machine schedule. The Governing Body has determined the need for on-going frequency of the audits. They will be reported in the Quality Assessment Improvement meeting 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 Clinical Manager 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. The Clinic Manager is responsible for overall compliance. The deficiency will be corrected by 8/10/2018.

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E031

On 7/20/2018, the Director of Operations met with the Clinic Manager and reviewed the Guidelines for Emergency Preparedness Plan:

- FMS-CS-IC-II-130-014A Emergency Preparedness Plan Policy
- FMS-CS-IC-II-130-013 D3 Patient Emergency Contact List
- FMS-CS-IC-II-130-013- D3 Staff Emergency Contact Information
- FMS-CS-IC-II-130-013D2 Facility Emergency Information Directory

Educational Emphasis was placed on:

- The facility must develop a communication plan for all patients (in-center and home).
- Create and maintain staff, patient and facility emergency information contact lists
- Quarterly, the Clinic Manager or Designee will review and update: The FKC Facility Emergency Information Directory
- Quarterly, the Clinic Manager will review and update: Patient Emergency Contact List, and Staff Emergency Contact Information to be provided to local emergency preparedness staff.
- By 7/27/2018 Patients will be provided with hard copies of the following information:
    1. Name, address and phone number of the dialysis facility.
    2. Name and phone number of their nephrologist
    3. Any organizational emergency contact information such as the Patient Emergency Number
    4. Emergency Kit Checklist
    5. Emergency Food and Water Supply
    6. Emergency Meal Plan
    7. Fresenius Kidney Care emergency information card with the (800) number to contact in the case of an emergency. 7/20/2018 Cards have been ordered, and will be handed out to patients when they arrive.

On 7/25/2018 Clinic Manager provided Staff meeting on the Emergency Preparedness Policy, and procedures with the Facility Specific Emergency Plan.
For those direct patient care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service was given on 7/26/2018, 7/27/2018.

Effective 8/1/2018, The Clinic Manager or designee will conduct monthly audits utilizing the Emergency Preparedness Tool for three months. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Emergency Preparedness Tool per QAI calendar.

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 Clinical Manager 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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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. The Clinic Manager is responsible for overall compliance. The deficiency will be corrected by 8/10/2018.

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E034

On 7/20/2018, the Director of Operations met with the Clinical Manager and reinforced the expectations and responsibilities of the facility on policies:

- FMS-CS-IC-II-130-001C FKC Annual Facility Local Disaster Management Agency Contact Information Plan
- FMS-CS-IC-II-130-001D1 Annual Notification Requirement Letter
- FMS-CS-IC-II-130-001D2 Local Emergency Operations Center Annual Contact Confirmation Form

Education emphasis was placed on:

- Director of Operations, and or Clinic Manager perform the annual contact to Local Disaster Management.
- On 7/20/2018 the EOC letter was found in the clinic and placed in the emergency binder.
- The found letter and confirmation is attached to the Plan of Correction sent to the State.
- The emergency plan will be adopted in Governing body on an annual basis.
- Ensure the emergency annual contact information is gone over during the annual review of the emergency plan in Governing Body.
- Emergency plan is discussed in Quality Assessment Improvement meeting on an annual basis, and quarterly with fire drills and emergency education for patients.

On 7/25/2018 Clinical Manager will hold Governing Body meeting to go over and readopt the annual emergency plan. The Governing Body will continue on-going annual review of the Emergency plan and point of contact with the local disaster management team. This will be covered annually 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 Clinical Manager 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. The Clinic Manager is responsible for overall compliance. The deficiency will be corrected by 8/10/2018.

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E036

On 7/25/2018 the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Emergency Preparedness Plan Policy
- FMS-CS-IC-II-130-013A Fire Drill Policy
- FMS-CS-IC-II-130-013C Fire Drill Procedure
- FMS-CS-IC-II-130-013D2 Patient Participation in Fire Drills
- FMS-CS-IC-II-130-014A Emergency Preparedness Policy
- FMS-CS-IC-II-130-011C Emergency Hand Crank Blood Pump Procedure
- FMC-CS-IC-II-130-027C Emergency Clamp and Disconnect Procedure

Education emphasis was placed on:

- Ensure All In center Hemodialysis patients are educated and knowledgeable on the Emergency Clamp and Disconnect Procedure.
- Ensure All In center Hemodialysis patients are able to verbalize to staff what they will do in an emergency.
- Ensure Patient education is performed on all new admissions, with patient signing the acknowledgement of education form, then placed in patient's chart.
- Ensure all facility staff practice and participate emergency preparedness on a routine basis.
- Routine basis is set forth in our policies as being, quarterly covering all patients and shifts.
- Ensure quarterly Fire Drills are documented and evaluated on a quarterly basis in the equip program for the Quality Assessment Improvement monthly meeting.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service on 7/26/2018, 7/27/2018.

Effective 8/1/2018, Clinical Manager or designee will conduct Facility wide Emergency/Fire Drill. This will be done daily, until all patient involvement, and every Staff have had documented involvement. This will be done utilizing Clinical Practice Checklist Audit tool for Fire Drill and disaster.
Effective 8/1/2018, The Clinical Manager or designee will complete an audit of all new admission patients to ensure emergency and disaster Fire Drill has been done and is present in the chart for the time span of 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once 100% Compliance is sustained, monitoring will be done through the Clinical Practice Checklist Audit tool for Fire Drill and disaster per the Quality Assessment Improvement Calendar, on a quarterly basis. The education with all new admissions, with forms signed will be reviewed in Quality Assessment Improvement through the Admission and Discharge workbook 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 Clinical Manager 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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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. The Clinic Manager is responsible for overall compliance. The deficiency will be corrected by 8/10/2018.

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E038

On 7/25/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Emergency Preparedness Plan Policy
- FMS-CS-IC-II-130-013A Fire Drill Policy
- FMS-CS-IC-II-130-013C Fire Drill Procedure
- FMS-CS-IC-II-130-013D2 Patient Participation in Fire Drills
- FMS-CS-IC-II-130-014A Emergency Preparedness Policy
- FMS-CS-IC-II-130-011C Emergency Hand Crank Blood Pump Procedure
- FMC-CS-IC-II-130-027C Emergency Clamp and Disconnect Procedure

Education emphasis was placed on:

- Ensure all staff are aware and knowledgeable on the Facility Specific Emergency Plan and how to use the binder, in an emergency or disaster including the following:
    - Contacts
    - Policies and procedures for geographical emergencies
    - Patient information and orders
- Ensure direct patient care staff are educated and knowledgeable on the Emergency Clamp and Disconnect Procedure.
- Ensure direct patient and non-direct patient care staff know what they will do in case of an evacuation for an emergency.
- Ensure all facility staff practice and participate emergency preparedness on a routine basis.
- Routine basis is set forth in our policies as being, quarterly for fire drills, 1 community drill, and 2 Table Top drills annually.
- Ensure Fire/disaster Drills are documented and evaluated on a quarterly basis in the equip program for the Quality Assessment Improvement monthly meeting.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service on 7/26/2018, 7/27/2018.

Effective 8/1/2018, Clinical Manager or designee will conduct Facility wide Emergency Drill. This will encompass every Staff and provide documented involvement. This will be done utilizing Clinical Practice Checklist Audit tool for Fire Drill and disaster. Once 100% Compliance is sustained, monitoring will be done through the Clinical Practice Checklist Audit tool for Fire Drill and disaster per the Quality Assessment Improvement Calendar, on a quarterly basis. The education with all new admissions, with forms signed will be reviewed in Quality Assessment Improvement through the Admission and Discharge workbook 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 Clinical Manager 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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E039

On 7/25/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D1 Facility Specific Disaster Safety Plan Form

Education emphasis was placed on:

- On 6/22/2018, Facility had a Loss of water. This actual disaster was documented, and analyzed in the Governing Body meeting held on 7/25/2018. Will be discussed in Quality Assessment Improvement Meeting for the month August. All documentation and performance of disaster is located in the Facility Specific Emergency Plan Book.
- Facility scheduled on 9/6/2018 a Community Disaster Drill with Fresenius Dialysis Community on Fire Disaster and Evacuation.
    - On 7/23/2018 contacted Panhandle Health district contacted about the next dates and subjects of the Community Disaster Drills. Was informed that there aren't any scheduled at the moment. There is a table top drill in the works for the end of September but no set date at this time.
    - Clinic Manager will be added to the email list to get information and include Hayden Lake Dialysis in the next drill.
    - Contacted local police department to participate in a community drill, was informed there were none scheduled at this time. Sent to voicemail for Sgt and left a message about scheduling one for just for our clinic.
    - Contacted Idaho State Police with the same answer, none scheduled at this time. Transferred to voicemail for Head of Police Department Chief, message left about scheduling just for our clinic.
    - Contacted Hayden Lake Fire Department and was told there was nothing planned at the moment, was sent to the voicemail of Deputy Fire Marshall. Left voicemail asking for them to call back to schedule a drill with our clinic.
    - Contacted Couer d'Alene Fire Department unable to get a hold of anyone there tried several times.
    - Due to not being able to schedule with anyone it was decided that Director of Operations for Northern Idaho, will be holding a community disaster drill with in the Fresenius Dialysis Community on 9/6/18 on Fire Disaster and Evacuation.

- Facility scheduled during Quality Assessment Improvement meeting in November, 2nd Table Top Drill on Fire.
- Ensure Facility participates in 2 Table top drills a year Documented in eQuip for the Quality Assessment Improvement Meeting.
- Ensure Facility participates in 1 Community Drill a year, Documented in eQuip for the Quality Assessment Improvement Meeting.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 7/26/2018, 7/27/2018.

On 7/25/2018, Clinical Manager held a Governing Body meeting with the schedule of the proposed dates for the 2 Table Top Drills and Community Drill. The Governing Body will continue on-going frequency of the 2 Table Top Drills and the 1 Community Based Drill. This will be discussed in the Quality Assessment Improvement meeting.

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