I D A H O D E P A R T M E N T O F
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 14, 2018

Tabitha Olson, Administrator
Moscow Dialysis Center
212 Rodeo Drive, Suite 110
Moscow, ID 83843

RE: Moscow Dialysis Center, Provider #132521

Dear Ms. Olson:

This is to advise you of the findings of the Medicare survey of Moscow Dialysis Center, which was conducted on August 31, 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 **September 27, 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

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

PRINTED: 09/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132521	A. BUILDING ______ B. WING ______	08/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSCOW DIALYSIS CENTER	212 RODEO DRIVE, SUITE 110 MOSCOW, ID 83843

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey at your facility from 8/27/18 - 8/30/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: FA - Facility Administrator RN - Registered Nurse	V 000	RECEIVED SEP 28 2018 FACILITY STANDARDS	
V 402	PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY CFR(s): 494.60(a) The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure patient safety. This failure impacted 8 of 8 incenter dialysis patients and 3 home therapy patients who frequented the facility, by not providing secure treatment areas protected from unauthorized persons. The findings include: Entry to the facility was made from a public sidewalk into a lobby/waiting area. On the right of the lobby was a hallway leading to the home therapy patient treatment area. On the left was a hallway leading to the incenter dialysis patient treatment area. These hallways were open, with	V 402	V402 A Facility Summary and Assessment was printed out and reviewed with Regional Director that the Facility would need to add two doors and a security shield for the AA office. On 9/10/18 the Facility Administrator (FA) put in a work order stating: Safety and Security- facility will be needed two doors; one towards the hallway to home modalities and break room and the other to the patient floor. Also added that we require a window placed in the AA office for security also. Plan of Action is to have the contracts bid the job to complete this task by 10/15/18. In the interim, signs have been placed indicating that only Davita teammates and/or Davita accompanied patients should enter the treatment area and home training department. Patients have also received a letter asking them not to enter either the treatment area or home training area unless accompanied or requested by DaVita teammates. The Governing Body will meet to review the work orders, and approve V402 cont on page 2	10/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tabitha Olsen FA/RN	FA	9/21/2018

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 402	Continued From page 1 no doors available. The lobby area was not visible to either of the patient treatment areas, allowing unauthorized persons free access to both patient treatment areas. In an interview on 8/29/18 at 3:00 PM, two RNs stated they had expressed concerns about the unsecured patient treatment areas to the facility corporation. In an interview on 8/29/18 at 1:00 PM, the biomed technician said he had been startled several times, while working in the water room, by persons who were in the building unannounced and unaccompanied. The facility failed to provide for patient safety.	V 402	V402 Continued from page 1 the timeline for when construction will take place and in patient care will be affected. The FA or designee will be responsible for the continuation of education on and safety of the patients and the staff until the construction is complete. FA or designee will continue to document the progress of the door installation and window placement in FHR. The governing body will meet and track progress monthly in QAPI/FHM. The FA as agent for the Governing Body is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/15/18
V 727	MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL CFR(s): 494.170(a) The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts. (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. This STANDARD is not met as evidenced by:	V 727	V727 1) The FA moved all medical records that were in a locked rolling chart cart into her locked FA office on 9/3/2018. Prior they were in the locked cart but in the AA office with no window shield. This plan of correction was completed as of the date 9/3/2018. Additionally, the FA completed an in-service with all teammates to let them know the change of location of the medical records. A Facility Summary and Assessment was printed out and reviewed with Regional Director that the Facility would need to add two doors and a security shield/window for the AA office. On 9/10/18 the Facility Administrator (FA) put in a work order stating: we will be required to place a window in the AA office for security also. Plan of Action is to have the contracts bid the job to complete this task by 10/15/18. V727 cont on page 3	10/15/18

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V 727	Continued From page 2 Based on observations and staff interview, it was determined the facility failed to keep patient records secure at all times, impacting 11 of 11 patients (Patients #1 - #11) who received services at the facility. This failure allowed the potential for the acquisition of confidential patient information by unauthorized persons. Findings include: An unattended reception area was present directly across the lobby area from the outside entry door. The reception area had an open door and an open window into an area containing desk seating, a copy machine, and an open file cabinet holding 11 patient charts. The area was not visible from or accessible to the patient treatment areas. From 8/27/18 - 8/30/18 the reception area, containing patient charts, was observed to be accessible to patients, family members, delivery persons, and the general public using the lobby. In an interview on 8/29/18 at 3:00 PM, the FA confirmed confidential patient information was unsecured and accessible to unauthorized persons. Medical records were not kept in a secured area with controlled access.	V 727	V727 Continued from page 2 After completion of window placement, the FA or designee will return medical records into AA office. FA or designee will continue to document the progress of the window placement in FHR. The governing body will meet and track progress monthly in QAPI/ FHM. The FA as agent for the Governing Body is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/15/18

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E 000	Initial Comments The following Emergency Preparedness deficiencies were cited during the recertification survey at your facility from 8/27/18 - 8/30/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: EP - Emergency Preparedness FA - Facility Administrator	E 000	RECEIVED SEP 28 2018 FACILITY STANDARDS	
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events	E 006	E006 Hazard Risk Assessment form North Central Health Coalition was sent to FA on 9/11/18 after meeting with the Health Care Liaison on 9/10/18. FA or designee is to revise the facility Risk Hazard Assessment Tool based of the community and the county assessments. Latah county emergency management is not required to have such a tool at this time. FA or designee will revise tool based of the North Central Health Coalition assessment tool and based off the current identified risks in our area at this time including unauthorized intruder. The Risk Assessment tool will be updated and reviewed and approved by the Governing Body along with a revised Emergency Drill calendar. The FA will review the emergency drill calendar and emergency drill evaluation forms monthly during QAPI/ Facility Health Meeting, with the Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/15/18

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

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E 006	Continued From page 1 identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on EP plan review and staff interview, it was determined the facility failed to develop an EP plan that included a facility specific risk assessment. This failure impacted 8 of 8 Incenter patients dialyzing at the facility, all staff employed by the facility, and 3 home patients who had frequent appointments, by allowing a risk to remain unaddressed in the facility's emergency response plan. The findings include: The facility was located adjacent to an outpatient mental health provider and shared a wall, a common sidewalk, and a parking lot. Additionally, the front door of the facility remained unlocked during business hours and the facility treatment floor was not secure. A review of the facility's EP plan, on 8/30/18 at 10:00 AM, showed a facility risk assessment identifying several risks including blizzard, wildfire, power failure and water failure. However, the entry of unauthorized intruders was not identified as a risk to the facility. During an interview on 8/29/18 at 3:00 PM, one RN stated "the cops are here all the time for next door." A comprehensive facility based risk assessment was not performed.	E 006		

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E 031	Continued From page 2	E 031	E031	
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. (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 EP communication plan 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 deficient practice had the potential to affect 11 of 11 patients (Patients #1 - #11) and staff at the	E 031	The facility Emergency Contact list has been up dated to include contact information for federal, state and local/community emergency management officials. The contact information has been placed in the Emergency Management Binder. The FA as agent for the Governing Body will review emergency contact information a minimum of annually and update the contact list as needed. The Governing Body will review the Emergency Management plan annually. The FA as agent for the Governing Body is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/15/18

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E 031	Continued From page 3 facility. This failure had the potential to hinder external emergency personnel response, and to hinder the coordination of patient care during an emergency. The findings include: On 8/30/18 at 10:00 AM the facility's EP communication plan was reviewed. The plan included several corporate contact phone numbers as well as that of the regional health district. The plan did not include contact information for federal, stae or local emergency management officials. In an interview at the time of the plan review, the FA confirmed the missing contact information. She said she had the phone number of one person at the county emergency preparednes agency, but had not included the number in the facility's communication plan and had not made contact with the person. 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 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	E 034		

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E 034	Continued From page 4 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 EP plan 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 for 11 of 11 patients (Patients #1 - #11) and staff at the facility. This failure had the potential to hinder response assistance and continuity of care for patients. The findings include: The facility's EP plan was reviewed on 8/30/18 at 10:00 AM. There was no documentation showing the facility had communication with emergency management 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 FA 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.	E 034	E034 1) The FA will review clinic needs in a meeting that our local emergency disaster puts on every other month; the next meeting will be held on 10/11/2018 at 0900 and FA or designee will attend this meeting and relay what the facility has in place for Emergency Management and what the facilities needs are in case of an emergency. This meeting is called the Local Emergency Planning and Committee that is held in the Latah County Courthouse in Moscow Idaho. Documentation of this meeting and future meetings, will be maintained in the facility Emergency Management binder. The FA will review facility needs a minimum of annually with local emergency management. Facility/FA will then also be involved with the North Central Healthcare Coalitions meetings/ emergency education. These meetings and emergency planning take place quarterly and there next meeting will be held on 12/6/2018. FA or designee and another member of the team will attend that meeting and review with them what facility needs we have and also what we can offer to the community from our clinic. If we will be using our building or any supplies that we can offer to the community. Documentation of this meeting will be maintained in the facility Emergency Management binder. The Governing Body will review and approve any plan revisions based on these two community Emergency Preparedness processes. The FA as agent for the Governing Body is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/15/18

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E 034	Continued From page 5 The facility failed to develop a plan for communication with local emergency management officials.	E 034		