IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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RECEIVED
FEB 27 2019
FACILITY STANDARDS

February 15, 2019

Karin Burton, Administrator
U S Renal Care Post Falls Dialysis
920 North Highway 41
Post Falls, ID 83854

RE: U S Renal Care Post Falls Dialysis, Provider #132529

Dear Ms. Burton:

This is to advise you of the findings of the Medicare survey of U S Renal Care Post Falls Dialysis, which was conducted on February 7, 2019.

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:

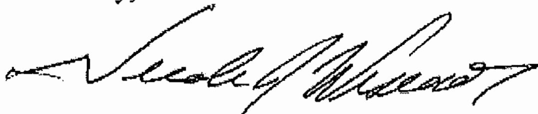
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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 **February 28, 2019,** 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/nw
Enclosures

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

PRINTED: 02/15/2019
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
	132529	A. BUILDING ______ B. WING ______	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U S RENAL CARE POST FALLS DIALYSIS	920 NORTH HIGHWAY 41 POST FALLS, ID 83854

(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 [CORE] The following deficiencies were cited during the recertification survey at your facility from 2/04/19 - 2/07/19. The surveyor conducting the survey was: Trish O'Hara, RN, CNN, HFS Acronyms used in this report include: AVF - Arteriovenous Fistula BFR - Blood Flow Rate CVC - Central Venous Catheter DFR - Dialysate Flow Rate EMR - Electronic Medical Record FA - Facility Administrator ICHD - Incenter Hemodialysis q - every QAPI - Quality Assurance Performance Improvement UF - Ultrafiltration (fluid removal)	V 000	RECEIVED FEB 27 2019 FACILITY STANDARDS	
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 occurrence/incident report review, treatment sheet review, policy review, and staff interview, it was determined the facility failed to ensure data related to occurrences/incidents was accurately collected. This failure directly	V 634	On 2/25/2018, the Facility Administrator, held a staff meeting with all in-center staff to review and re-educate on the following policies: • POLICY # C-AD-0510 POLICY : INTRODUCTION TO QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) • POLICY # C-AD-0510 POLICY: OCCURRENCE/ INCIDENT REPORTS INCLUDING	05/22/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] RN CCN	Facility Administrator	2/25/2019

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 634	Continued From page 1 impacted 5 of 7 ICHD patients (Patients #1 - #5) whose records were reviewed, and had the potential to impact all patients receiving care at the facility. This failure resulted in the inability of the QAPI committee to identify problem indicators, and the inability to devise an effective action plan to correct the problem indicators. The findings include: The facility's policy titled OCCURRENCE/INCIDENT REPORTS INCLUDING CLOSE CALL/NEAR MISS AND COMMUNICATION MATRIX, revised 5/2018, stated "Patient occurrences/incidents most commonly include all injuries, accidents, medication errors, treatment errors, and unexpected reactions to routine treatment." The policy include a list of 51 events for which data was to be collected for review by the QAPI committee. These events included dialysis prescription errors and missed/incorrect medication. 1. Medication errors were not identified and reported as follows: a. Patient #1 was a 60 year old male who dialyzed using a CVC. Thirteen treatment sheets, from 1/03/19 - 2/02/19, were reviewed. Each of the treatment sheets included a physician's order for maintenance Heparin to be administered at a rate of 1500 units/hour for the entirety of his 4 hour treatment, for a total of 6000 units. Total maintenance Heparin administration was documented as 4500 units on 1/03/19, and 5000 units on 1/10/19, 1/12/19, and 1/19/19, and 0 units on 2/02/19. In an interview on 2/07/19 at 11:00 a.m., the FA	V 634	CLOSE CALL/NEAR MISS AND COMMUNICATION MATRIX • POLICY # C-ID-0020 POLICY : ANTICOAGULATION DURING HEMODIALYSIS For those staff members that were not in attendance of the staff meeting, they were given 1:1 educational in-service on 2/25/2018. • Effective 2/22/2019, the Facility Administrator or designee will conduct bi-weekly preparation for QAPI audits using the Incident report Summary log with documentation of checking adverse events reported from staff. QAPI meeting minutes to have a greater focus on adverse events and their outcomes over the next 6 months. This will be tracked using the Incident reporting audit tool with emphasis of audits on: o Ensure complete and accurate documentation of occurrence/incident are completed by staff and reviewed by Facility Administrator. o Ensure event has been entered into Occurrence/Incident report log. o Ensure occurrence/incident is documented in patient health record.	

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V 634	Continued From page 2 confirmed Patient #1 had not received his prescribed amount of maintenance Heparin during 5 treatments and no occurrence reports had been completed for the medication errors. b. Patient #2 was a 63 year old male who dialyzed using a CVC and a maturing AVF. Review of 7 treatment sheets, from 1/05/19 - 1/19/19, showed dialysis was performed utilizing his AVF and his CVC from 1/05/19 - 1/08/19. Only the AVF was used from 1/10/19 - 1/19/19. The seven treatment sheets reviewed included a physician's order for maintenance Heparin to be administered at a rate of 1000 units/hour for the entirety of his 4 hour treatment, for a total of 4000 units. Total maintenance Heparin administration was documented as: 1/05/19 - 2500 units 1/08/19 - 2500 units 1/10/19 - 2000 units 1/15/19 - 2500 units 1/17/19 - 1700 units 1/19/19 - 2000 units In an interview on 2/07/19 at 11:00 a.m., the FA confirmed Patient #2 had not received his prescribed amount of maintenance Heparin during 6 treatments and no occurrence reports had been completed for the medication errors. c. Patient #3 was a 57 year old male. Fourteen treatment sheets, from 1/02/19 - 2/02/19, were reviewed and included a physician's order for maintenance Heparin to be administered at 1000 units/hour for 3 hours, for a total of 3000 units. The 14 reviewed treatment sheets documented total maintenance Heparin administration as 0.0	V 634	o Ensure all occurrence/ incidents are reviewed in QAPI evaluating for root causes and trends. o If trends are found, a root cause analysis will be completed and documented in QAPI. o Implementation of an Action Plan will be completed during the QAPI meeting. • Effective 2/22/2019 , the Facility Administrator or designee will audit 15% of in-center hemodialysis treatment sheets weekly for 4 weeks utilizing flowsheet audit tool. These audits will be performed over multiple days and shifts to ensure a variety of patients and staff are audited on accurately reporting and documenting Occurrence/Incidents. This will be tracked using the Flow Sheet Audit Tool. • Adherence to the policy will result in the frequency being reduced to 15% bi-weekly for 2 months utilizing the flowsheet audit tool. Once compliance is sustained on-going monitoring will be done through the medical records audit per QAPI calendar. • Any on-going non-compliance by staff will be addressed with	

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V 634	Continued From page 3 units. In an interview on 2/07/19 at 11:00 a.m., the FA confirmed the documented Heparin administration during 14 treatments, and confirmed no occurrence reports had been completed for the medication errors. 2. Treatment errors were not identified and reported as follows: a. Patient #3 was a 57 year old male. Fourteen treatment sheets, from 1/02/19 - 2/10/19, were reviewed and showed his physician ordered prescription included a BFR of 500 ml/min. Average BFR was documented as: 1/02/19 - 408 ml/min. 1/04/19 - 422 ml/min. 1/07/19 - 414 ml/min. 1/09/19 - 418 ml/min. 1/11/19 - 390 ml/min. 1/14/19 - 450 ml/min. 1/16/19 - 414 ml/min. 1/18/19 - 450 ml/min. 1/21/19 - 400 ml/min. 1/23/19 - 414 ml/min. 1/25/19 - 414 ml/min. 1/28/19 - 408 ml/min. 1/30/19 - 408 ml/min. 2/01/19 - 450 ml/min. There was no nursing documentation indicating why Patient #3's BFR was not maintained at 500 ml/hour. b. Patient #4 was a 57 year old male who started dialyzing once a week at the facility on 1/22/19. Two treatment sheets, from 1/22/19 - 2/05/19,	V 634	corrective action as appropriate. • Audit results will be reviewed and presented to the QAPI team beginning March 2019. The QAPI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained. • Facility Administrator is responsible to ensure all documentation required to ensure the resolution of the deficiencies is provided to the QAPI committee on an monthly basis. Based on audit results, the QAPI committee will make determination as to the frequency of audits moving forward.	

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V 634	Continued From page 4 were reviewed and showed his physician ordered prescription included a BFR of 400 ml/min. On 2/05/19 Patient #4's average BFR was documented at 350 ml/min. There was no nursing documentation indicating why Patient #4's BFR was not maintained at 400 ml/hour. c. Patient #5 was a 41 year old female. Thirteen treatment sheets, from 1/04/19 - 2/01/19, were reviewed and showed her physician ordered prescription included a BFR of 450 ml/min. Average BFR was documented as: 1/04/19 - 400 ml/min. 1/14/19 - 400 ml/min. 1/16/19 - 410 ml/min. 1/25/19 - 400 ml/min. There was no nursing documentation indicating why Patient #5's BFR was not maintained at 450 ml/hour. In an interview on 2/07/19 at 11:00 a.m., the FA confirmed prescribed BFR was not maintained for Patients #3, #4, and #5. She confirmed no occurrence reports had been completed for the treatment errors. Occurrence reports were not competed for medication and treatment errors for Patients #1 - #5.	V 634		
V 713	MD RESP-STAFF ED, TRAINING & PERFORM CFR(s): 494.150(b) Medical director responsibilities include, but are not limited to, the following:	V 713	On 2/25/2018, the Facility Administrator, held a staff meeting with all in-center staff to review and re-educate on the following policies:	5/22/2019

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V 713	Continued From page 5 (b) Staff education, training, and performance. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure staff followed facility policy regarding patient monitoring during dialysis treatments. This directly impacted 6 of 7 patients (Patients #1 - #3 and #5 - #7) whose treatment sheets were reviewed, and had the potential to impact all patients receiving treatment at the facility. Lack of appropriate monitoring placed patients at risk of unaddressed complications. The findings include: The patients' dialysis machines automatically transferred data to the EMR including vital signs, needle pressures, BFR, DFR, UF, and Heparin administration. A policy titled INTRADIALYTIC MONITORING OF PATIENT, revised 10/2018, stated, "The nurse will assess the following parameters during dialysis: Patient: - Must be in direct view of a staff member at all times - Vital signs every 30 minutes - Vascular access patency - needles or connections in place, secure and visible at all times: site clean and dry; venous pressure; arterial pressure; signs and symptoms of recirculation; signs and symptoms of infiltration - Anticoagulation effectiveness - Well being; level of consciousness - Delivery of dialysis prescription - Response to treatment - Comment regarding patient status at least q 30	V 713	• POLICY # C-ID-0010 POLICY : INTRADIALYTIC MONITORING OF PATIENT For those staff members that were not in attendance of the staff meeting, they were given 1:1 educational in-service on 2/25/2018. • Effective 2/22/2019 , the Facility Administrator or designee will audit 15% of in-center hemodialysis treatment sheets weekly for 4 weeks utilizing flowsheet audit tool. These audits will be performed over multiple days and shifts to ensure a variety of patients and staff are audited on accurately reporting and documenting Occurrence/Incidents. This will be tracked using the Flow Sheet Audit Tool. • Adherence to the policy will result in the frequency being reduced to 15% bi-weekly for 2 months utilizing the flowsheet audit tool. Once compliance is sustained on-going monitoring will be done through the medical records audit per QAPI calendar.	

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V 713	Continued From page 6	V 713		

Continued From page 6

minutes
- Observations every 30 minutes"

1. Patient #1 was a 60 year old male. Thirteen treatment sheets, from 1/03/19 - 2/02/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/03/19 from 8:51 a.m. - 10:02 a.m.
1/07/19 from 7:00 a.m. - 8:04 a.m. and 9:34 a.m. - 10:25 a.m.
1/10/19 from 8:38 a.m. - 9:38 a.m.
1/15/19 from 10:33 a.m. - 11:32 a.m.
1/17/19 from 8:03 a.m. - 9:07 a.m., 9:07 a.m. - 10:08 a.m., and 10:08 a.m. - 11:26 a.m.
1/19/19 from 10:10 a.m. - 11:33 a.m.
1/24/19 from 11:07 a.m. - 12:04 a.m. during an episode of hypotension
1/31/19 from 9:32 a.m. - 10:42 a.m. and 10:42 a.m. - 11:53 a.m. during an episode of hypotension.

2. Patient #2 was a 63 year old male. Seven treatment sheets, from 1/05/19 - 1/19/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/05/19 from 11:01 a.m. - 12:17 p.m.
1/08/19 from 11:02 a.m. - 12:19 p.m.
1/10/19 from 8:43 a.m. - 10:04 a.m. and 10:04 a.m. - 11:23 a.m.
1/10/19 - No data was transferred from 8:05 a.m. - 8:43 a.m., indicating the EMR transfer button had not been activated. Patient #2's treatment was shortened by 22 minutes with no documented reason.
1/17/19 from 8:15 a.m. - 10:29 a.m. and 10:30 a.m. - 12:17 a.m.
1/19/19 from 10:11 a.m. - 11:33 a.m.

V 713 (Provider's Plan of Correction):

- Any on-going non-compliance by staff will be addressed with corrective action as appropriate.
- Audit results will be reviewed and presented to the QAPI team beginning March 2019. The QAPI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- Facility Administrator is responsible to ensure all documentation required to ensure the resolution of the deficiencies is provided to the QAPI committee on an monthly basis. Based on audit results, the QAPI committee will make determination as to the frequency of audits moving forward.

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V 713	Continued From page 7	V 713		

3. Patient #3 was a 57 year old male. Fourteen treatment sheets, from 1/02/19 - 2/01/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/04/19 from 7:38 a.m. - 8:55 a.m.
1/07/19 from 6:43 a.m. - 8:04 a.m.
1/09/19 from 6:34 a.m. - 7:38 a.m. and 8:07 a.m. - 9:14 a.m.
1/11/19 from 7:34 a.m. - 9:15 a.m. and 9:17 a.m. - 10:15 a.m.
1/14/19 from 9:36 a.m. - 10:25 a.m.
1/16/19 from 8:36 a.m. - 9:40 a.m.
1/18/19 from 9:08 a.m. - 10:19 a.m.
1/21/19 from 9:07 a.m. - 10:25 a.m.
1/23/19 from 8:06 a.m. - 9:10 a.m.
1/28/19 from 9:05 a.m. - 10:02 a.m.
1/30/19 from 9:08 a.m. - 10:15 a.m.
2/01/19 from 8:33 a.m. - 9:35 a.m.

4. Patient #5 was a 41 year old female. Thirteen treatment sheets, from 1/04/19 - 2/01/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/04/19 - from 9:48 a.m. - 11:04 a.m. during an episode of hypotension.
1/07/19 - from 9:49 a.m. - 10:40 a.m.
1/09/19 from 7:21 a.m. - 8:42 a.m. and 9:34 a.m. - 10:42 a.m.
1/11/19 from 7:03 a.m. - 7:58 a.m. and 9:40 a.m. - 10:32 a.m.
1/23/19 from 10:08 a.m. - 11:06 a.m.
1/25/19 from 8:49 a.m. - 11:12 a.m.
1/28/19 from 9:03 a.m. - 10:21 a.m.
1/30/19 from 9:44 a.m. - 10:44 a.m.
2/01/19 from 8:10 a.m. - 9:10 a.m., 9:10 a.m. - 10:06 a.m., and 10:06 a.m. - 11:10 a.m.

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V 713	Continued From page 8	V 713		

5. Patient #6 was a 40 year old male. Fourteen treatment sheets, from 1/02/19 - 2/01/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/04/19 from 7:03 a.m. - 8:02 a.m., 8:02 a.m. - 9:02 a.m., and 9:32 a.m. - 10:49 a.m. during an episode of hypotension.
1/07/19 from 7:06 a.m. - 8:10 a.m. and 10:12 a.m. - 11:04 a.m.
1/11/19 from 7:34 a.m. - 8:39 a.m. and 9:02 a.m. - 10:49 a.m.
1/16/19 from 9:35 a.m. - 10:53 a.m.
1/18/19 from 8:33 a.m. - 9:33 a.m.
1/23/19 from 8:07 a.m. - 9:08 a.m. and 9:34 a.m. - 10:47 a.m.
1/25/19 from 8:38 a.m. - 10:49 a.m.
1/30/19 from 9:01 a.m. - 10:06 a.m.
2/01/19 from 7:31 a.m. - 9:28 a.m. during an episode of hypotension, and 9:38 a.m. - 10:31 a.m. when Patient #6 requested early treatment termination.

6. Patient #7 was a 66 year old female. Ten treatment sheets, from 1/02/19 - 2/01/19, were reviewed. Examples of missed monitoring and assessment included, but were not limited to:

1/07/19 from 1:15 p.m. - 2:49 p.m.
1/11/19 from 1:35 p.m. - 2:33 p.m.
1/25/19 from 2:07 p.m. - 3:09 p.m.
1/28/19 from 12:38 p.m. - 1:35 p.m.

In an interview on 2/07/19 at 11:00 a.m., the FA said the expectation for staff was to assess the patient, as well as review data entered into the EMR by the dialysis machine, every 30 minutes.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132529	A. BUILDING ______ B. WING ______	02/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U S RENAL CARE POST FALLS DIALYSIS	920 NORTH HIGHWAY 41 POST FALLS, ID 83854

(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 713	Continued From page 9 Patients were not appropriately monitored during treatments.	V 713		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments No deficiencies were cited during the Emergency Preparedness survey of your facility conducted from 2 /04/19 - 2/07/19. U.S. Renalcare - Post Falls is in compliance with the requirements of CFR 494.62. The surveyor conducting the survey was: Trish O'Hara RN, HFS	E 000	RECEIVED FEB 27 2019 FACILITY STANDARDS	

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.