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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 12, 2019

Ms. Terry Whybark, Administrator
Palouse Dialysis Center
723 South Main Street
Moscow, ID 83843

RE: Palouse Dialysis Center, Provider #132520

Dear Ms. Whybark:

This is to advise you of the findings of the Medicare survey of Palouse Dialysis Center, which was conducted on March 8, 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 **March 25, 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: 03/11/2019
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
	132520	A. BUILDING ______ B. WING ______	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOUSE DIALYSIS CENTER	723 SOUTH MAIN STREET MOSCOW, ID 83843

(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 3/04/19 - 3/07/19. The surveyor conducting the survey was: Trish O'Hara, RN, CNN, HFS Acronyms used in this report include: FA - Facility Administrator QAPI - Quality Assurance Performance Improvement	V 000	RECEIVED MAR 25 2019 FACILITY STANDARDS	
V 581	H-IDT RESP FOR SERVICES=IN-CENTER PTS CFR(s): 494.100 A dialysis facility that is certified to provide services to home patients must ensure through its interdisciplinary team, that home dialysis services are at least equivalent to those provided to in-facility patients and meet all applicable conditions of this part. This STANDARD is not met as evidenced by: Based on staff interview, and QAPI meeting minutes review, it was determined the facility failed to provide home therapies with QAPI representation equivalent to that provided for the in-center program. This directly impacted 3 of 3 home dialysis patients (Patients #1, #2, and #3) whose records were reviewed. This failure prevented home therapies data review from being discussed, assessed, and monitored by personnel familiar with the patients and data. The findings include: QAPI meeting minutes were reviewed for the last	V 581		

[illegible signature] CM/RN — CM/RN — 3/22/19

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

[illegible signature] — Director of Operations — 3/22/19

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132520	A. BUILDING _____ B. WING _____	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOUSE DIALYSIS CENTER	723 SOUTH MAIN STREET MOSCOW, ID 83843

(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 000	Initial Comments No deficiencies were cited during the recertification of your facility, from 3/04/19 - 3/07/19, for Emergency Preparedness. Palouse Dialysis Center is in compliance with the requirements of CFR 494.62. The surveyor conducting the survey was: Trish O'Hara RN, CNN, HFS	E 000		

RECEIVED
MAR 25 2019
FACILITY STANDARDS

Jerry Whitbeck — RN/CM — 3/22/19
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Matt Sanke — Director of Operations — 3/22/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Fresenius Medical Care
Dba Palouse
Plan of Correction for
Medicare ESRD Recertification Survey
Date of Survey: 3/7/2019

V581

The Clinic Manager/designee will educate and elicit input from relevant staff by 3/15/2019 on the expectations and responsibilities to comply with the following policies and procedures:

- FMS-CS-IC-I-101-001A Quality Assessment and Performance Improvement Program (QAPI) Policy

Educational Emphasis was placed on:

- Ensure Quality Assessment Improvement Team include the Home Therapies Program personnel in the Quality Assessment and Performance Improvement Program.
- Home Therapies Program Manager, or Home RN designee will participate in all monthly Quality Assessment and Performance Improvement meetings.

Effective 3/11/2019, the Clinical Manager or designee will send the Home Therapies Program Manager or Home RN designee the invite for all monthly Quality Assessment Improvement meetings. This will be on going. Compliance will be indicated by the Meeting Minutes for attendance. Once compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement calendar with oversight from the Governing Body.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed through corrective action as appropriate.
The Clinical Manager is responsible for reviewing, analyzing, and trending all data and 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 for presenting 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 for providing oversight, review findings, and take actions as appropriate.

The Governing Body is responsible for providing 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.

Documentation of education, monitoring, Quality Assessment Improvement, and Governing Body is available for review.

The Clinic Manager is responsible for overall compliance.

Completion Date: 4/15/2019

Terry Whydark 3/22/19