



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

July 23, 2012

Clinton Fairless, Administrator
Post Falls Dialysis Unit
1300 East Mullan, Suite 1200
Post Falls, ID 83854

RE: Post Falls Dialysis Unit, Provider #132508

Dear Mr. Fairless:

This is to advise you of the findings of the Medicare survey of Post Falls Dialysis Unit, which was conducted on July 13, 2012.

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.

Clinton Fairless, Administrator
July 23, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **August 2, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm
Enclosures

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

PRINTED: 07/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2012
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NAME OF PROVIDER OR SUPPLIER POST FALLS DIALYSIS UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 EAST MULLAN, SUITE 1200 POST FALLS, ID 83854
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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V 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the survey was:</p> <p>Trish O'Hara, R.N.</p> <p>Acronyms used in this report include:</p> <p>CVC - Central Venous Catheter BFR - Blood Flow Rate EDW - Estimated Dry Weight (a weight where the patient has no symptoms of fluid overload or dehydration) EMR - Electronic Medical Record HD - Hemodialysis kg - kilogram (1 kilogram = 2.2 pounds) MAT - Measures Assessment Tool ml - milliliter (30 milliliter = 1 ounce) PCT - Patient Care Technician POC - Plan of Care QAI - Quality Assurance and Improvement</p>	V 000	<p style="text-align: center;">RECEIVED AUG 06 2012 FACILITY STANDARDS</p>	
V 116	<p>494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT</p> <p>Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.</p> <p>-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient.</p> <p>-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should</p>	V 116		<p>Please see attached documents, Goals less than or equal to sixty days.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Trish O'Hara* TITLE: *Idaho Area Mgr* (X6) DATE: *8-13-12*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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V 116	<p>Continued From page 1</p> <p>not be returned to a common clean area or used on other patients.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure supplies were dedicated for use on a single patient. This failure directly impacted 11 of 11 patients (Patients #2 - #12) observed, who had upper extremity accesses, and had the potential for cross contamination and infection of all patients receiving treatment in the facility. Findings include:</p> <p>During an observation on 7/11/12 from 10:00 AM - 12:00 PM, precut strips of tape were noted to be stuck to a sheet of laminate attached to a clipboard on the supply cart. Three patient care technicians were observed accessing these strips of tape, taking them to patient care stations, and using them to secure vascular access needles for patients having dialysis initiated on the second shift of the treatment day (Patients #2 - #12).</p> <p>At the time of the observation, a PCT said she was trained to not let tape strips hang down on the edge of the chairside table. She said she had not been trained to dedicate tape rolls to individual patients. The facility nurse manager was present at the time of the observation. She confirmed that tape strips should be not be obtained from a communal source and taken to individual patient care stations.</p> <p>The facility failed to ensure supplies that could not be disinfected were dedicated to a single patient.</p>	V 116	<p><i>Please see attached documents. Goals less than or equal to sixty days.</i></p>		

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V 403	<p>494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a refrigerator was maintained in a manner appropriate for the storage of medications. This failure had the potential to expose all patients to contaminated medications. Findings include:</p> <p>On 7/11/12 at 11:00 AM, an observation included inspection of the refrigerator in the medication preparation area of the facility. Four doses of Alteplase (a drug instilled into CVCs to dissolve clots) were observed in the crisper drawer of the refrigerator. The boxes containing the drug doses were wet and covered with ice. Further inspection showed standing water on the top shelf of the refrigerator.</p> <p>Full prescribing information, provided by the drug manufacturer and included in the package insert, directed storage of Alteplase at refrigerated temperatures of 36 - 46 degrees Fahrenheit.</p> <p>The charge nurse and the nurse manager were present at the time of the inspection. The charge nurse stated the refrigerator temperature was checked daily but said she was unaware of the presence of water and ice in the refrigerator. She</p>	V 403	<p><i>Please see attached documents</i></p> <p><i>Goals less than or equal to sixty days.</i></p>	

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V 403	Continued From page 3 further confirmed that the condition of the medication provided potential for cross contamination to patients as well as potential for decreased efficacy.	V 403			
V 463	The facility failed to maintain a properly functioning refrigerator for the storage of medications. 494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure patients' rights to receive care as outlined in their POC was upheld for 3 of 4 patients, (Patients #1 - #3) whose treatment records were reviewed. This resulted in patients being left at risk for complications of inadequate dialysis and fluid overload. Findings include: 1. Patients did not receive care as specified in their POCs as follows: a. Patient #1 was a 34 year old male who had been dialyzing at the facility since 5/30/06. Eleven treatments, from 6/11/12 - 7/4/12, were reviewed for BFR. Patient #1 did not attain his prescribed BFR during 11 of 11, or 100% of treatments reviewed, leaving him at risk for complications of inadequate dialysis. The	V 463	<i>Please see attached documents Goals less than or equal to sixty days.</i>		

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V 463	<p>Continued From page 4 following was documented:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>BFR ordered</th> <th>BFR actual</th> </tr> </thead> <tbody> <tr><td>6/11/12</td><td>400 ml/min</td><td>340 ml/min</td></tr> <tr><td>6/13/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/15/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/18/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/20/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/22/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/25/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> <tr><td>6/27/12</td><td>400 ml/min</td><td>320 ml/min</td></tr> <tr><td>6/29/12</td><td>400 ml/min</td><td>360 ml/min</td></tr> <tr><td>7/2/12</td><td>400 ml/min</td><td>360 ml/min</td></tr> <tr><td>7/4/12</td><td>400 ml/min</td><td>350 ml/min</td></tr> </tbody> </table> <p>Additionally, eleven treatments, from 6/11 - 7/4/12, were reviewed for dialysis treatment times. Patient #1 did not complete his entire prescribed treatment time for 8 of 11, or 72% of treatments reviewed, leaving him at risk for complications of inadequate dialysis. The following was documented:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Ordered time</th> <th>Actual time</th> </tr> </thead> <tbody> <tr><td>6/15/12</td><td>225 minutes</td><td>159 minutes</td></tr> <tr><td>6/20/12</td><td>225 minutes</td><td>201 minutes</td></tr> <tr><td>6/22/12</td><td>225 minutes</td><td>149 minutes</td></tr> <tr><td>6/25/12</td><td>225 minutes</td><td>222 minutes</td></tr> <tr><td>6/27/12</td><td>225 minutes</td><td>157 minutes</td></tr> <tr><td>6/29/12</td><td>225 minutes</td><td>166 minutes</td></tr> <tr><td>7/2/12</td><td>225 minutes</td><td>189 minutes</td></tr> <tr><td>7/4/12</td><td>225 minutes</td><td>190 minutes</td></tr> </tbody> </table> <p>This represented a cumulative loss of 367 minutes of dialysis time by Patient #1 during a 19 day period. There was no documentation in Patient #1's record showing he had been offered additional treatments to replace this missed time.</p>	Date	BFR ordered	BFR actual	6/11/12	400 ml/min	340 ml/min	6/13/12	400 ml/min	350 ml/min	6/15/12	400 ml/min	350 ml/min	6/18/12	400 ml/min	350 ml/min	6/20/12	400 ml/min	350 ml/min	6/22/12	400 ml/min	350 ml/min	6/25/12	400 ml/min	350 ml/min	6/27/12	400 ml/min	320 ml/min	6/29/12	400 ml/min	360 ml/min	7/2/12	400 ml/min	360 ml/min	7/4/12	400 ml/min	350 ml/min	Date	Ordered time	Actual time	6/15/12	225 minutes	159 minutes	6/20/12	225 minutes	201 minutes	6/22/12	225 minutes	149 minutes	6/25/12	225 minutes	222 minutes	6/27/12	225 minutes	157 minutes	6/29/12	225 minutes	166 minutes	7/2/12	225 minutes	189 minutes	7/4/12	225 minutes	190 minutes	V 463	<p><i>Please see attached documents</i></p> <p><i>Goals less than or equal to sixty days.</i></p>	
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V 463	Continued From page 5 b. Patient #3 was a 43 year old male who had been dialyzing at the facility since 7/12/07. Ten treatments, from 6/13/12 - 7/6/12, were reviewed for treatment times. Patient #3 did not complete his entire prescribed treatment time for 10 of 10, or 100% of treatments reviewed, leaving him at risk for complications of inadequate dialysis. The following was documented: <table border="1"> <thead> <tr> <th>Date</th> <th>Ordered time</th> <th>Actual time</th> </tr> </thead> <tbody> <tr><td>6/13/12</td><td>210 minutes</td><td>180 minutes</td></tr> <tr><td>6/15/12</td><td>210 minutes</td><td>178 minutes</td></tr> <tr><td>6/18/12</td><td>210 minutes</td><td>182 minutes</td></tr> <tr><td>6/20/12</td><td>210 minutes</td><td>180 minutes</td></tr> <tr><td>6/22/12</td><td>210 minutes</td><td>186 minutes</td></tr> <tr><td>6/25/12</td><td>210 minutes</td><td>185 minutes</td></tr> <tr><td>6/27/12</td><td>210 minutes</td><td>0 minutes</td></tr> <tr><td>7/2/12</td><td>210 minutes</td><td>177 minutes</td></tr> <tr><td>7/4/12</td><td>210 minutes</td><td>177 minutes</td></tr> <tr><td>7/6/12</td><td>210 minutes</td><td>158 minutes</td></tr> </tbody> </table> <p>This represented a cumulative loss of 497 minutes of dialysis time by Patient #3 during a 21 day period. There was no documentation in Patient #3's record showing he had been offered additional treatments to replace this missed time.</p> <p>In an interview on 7/9/12 at 5:00 PM, the medical director explained the tracking of missed treatments. She said the nurse talked to the patient after one missed treatment. If a patient missed more than one treatment in a month the social worker talked to the patient and placed the patient on a missed treatment initiative. She said she was made aware of all patients' missed treatments during monthly rounds.</p>	Date	Ordered time	Actual time	6/13/12	210 minutes	180 minutes	6/15/12	210 minutes	178 minutes	6/18/12	210 minutes	182 minutes	6/20/12	210 minutes	180 minutes	6/22/12	210 minutes	186 minutes	6/25/12	210 minutes	185 minutes	6/27/12	210 minutes	0 minutes	7/2/12	210 minutes	177 minutes	7/4/12	210 minutes	177 minutes	7/6/12	210 minutes	158 minutes	V 463	<i>Please see the attached documents</i> <i>Goals Less than or equal to sixty days.</i>	
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V 463	<p>Continued From page 6</p> <p>In an interview on 7/12/12 at 9:00 AM, the nurse manager said missed treatments were tracked and trended for QAI purposes, but shortened treatments were not.</p> <p>c. Patient #2 was a 37 year old male who had been dialyzing at the facility since 6/11/11. Twelve treatments, from 6/11/12 - 7/6/12, were reviewed for EDW results. Patient #2 did not attain his EDW during 6 of 12, or 50% of treatments reviewed, leaving him at risk for complications of fluid overload. The following was documented:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>EDW</th> <th>Post wt.</th> </tr> </thead> <tbody> <tr> <td>6/11/12</td> <td>60 kg</td> <td>61.6 kg</td> </tr> <tr> <td>6/13/12</td> <td>60 kg</td> <td>60.8 kg</td> </tr> <tr> <td>6/18/12</td> <td>60.5 kg</td> <td>62.2 kg</td> </tr> <tr> <td>6/25/12</td> <td>60.5 kg</td> <td>62.4 kg</td> </tr> <tr> <td>7/04/12</td> <td>60.5 kg</td> <td>61.2 kg</td> </tr> <tr> <td>7/06/12</td> <td>60.5 kg</td> <td>61.1 kg</td> </tr> </tbody> </table> <p>In an interview on 7/12/12 at 9:00 AM, the nurse manager said there was no process in place to track and trend patients' post dialysis weights or compare them to the patients' prescribed EDW. She said it was understood by staff that a prescribed EDW included a variance of plus or minus .5 kg but there was no facility policy addressing this issue. She further stated that staff used a "Crit line" to evaluate patients' EDW if they felt it was necessary, but there was no facility policy stating when a "Crit line" should be used.</p> <p>The facility failed to ensure 2 patients received prescribed dialysis times, 1 patient received prescribed BFR, and 1 patient attained prescribed</p>	Date	EDW	Post wt.	6/11/12	60 kg	61.6 kg	6/13/12	60 kg	60.8 kg	6/18/12	60.5 kg	62.2 kg	6/25/12	60.5 kg	62.4 kg	7/04/12	60.5 kg	61.2 kg	7/06/12	60.5 kg	61.1 kg	V 463	<p><i>Please see the attached documents</i></p> <p><i>Goals less than or equal to sixty days.</i></p>	
Date	EDW	Post wt.																							
6/11/12	60 kg	61.6 kg																							
6/13/12	60 kg	60.8 kg																							
6/18/12	60.5 kg	62.2 kg																							
6/25/12	60.5 kg	62.4 kg																							
7/04/12	60.5 kg	61.2 kg																							
7/06/12	60.5 kg	61.1 kg																							

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V 463	Continued From page 7 EDW.	V 463	<p><i>Please see the attached documents</i></p> <p><i>Goals less than or equal to sixty days</i></p>		
V 562	<p>494.90(d) POC-PT/FAMILY EDUCATION & TRAINING</p> <p>The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that periodic re-education was provided for 4 of 4 patients (Patients #1 - #4) whose records were reviewed. This failure put patients at potential risk for poor outcomes due to lack of information. Findings include:</p> <p>1. Patient #1 was a 34 year old male who had been dialyzing at the facility since 5/30/06 using an upper extremity native fistula vascular access. There was no documentation found in Patient #1's record showing he had been reinstructed in infection prevention, treatment modalities, or care of the vascular access since his initial education at the time of his admission to the facility.</p> <p>2. Patient #2 was a 37 year old male who had been dialyzing at the facility since 6/11/11 using an upper extremity native fistula vascular access. There was no documentation found in Patient #2's record showing he had been reinstructed in infection prevention, treatment modalities, or care of the vascular access since his initial education</p>	V 562			

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V 562	Continued From page 8 at the time of his admission to the facility. 3. Patient #3 was a 43 year old male who had been dialyzing at the facility since 7/12/07 using an upper extremity graft vascular access. There was no documentation found in Patient #3's record showing he had been reinstructed in infection prevention, treatment modalities, or care of the vascular access since his initial education at the time of his admission to the facility. 4. Patient #4 was a 38 year old female who had been dialyzing at the facility since 10/22/08 using an upper extremity native fistula vascular access. There was no documentation found in Patient #4's record showing she had been reinstructed in infection prevention, treatment modalities, or care of the vascular access since her initial education at the time of her admission to the facility. In an interview on 7/12/12 at 9:00 AM, the facility nurse manager confirmed the lack of documented periodic education for Patients #1 - #4. She said that informal, undocumented education occurred at the chairside by PCTs on a daily basis. However, she said the company expectation was for a licensed nurse to provide all education to patients and the nurses did not have time to provide this required periodic re-education. The facility failed to provide 4 patients with periodic education in the areas of infection control, care of the vascular access, and treatment modalities.	V 562	<i>Please see the attached documents Goals less than or equal to sixty days.</i>		
V 626	494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL	V 626			

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V 626	<p>Continued From page 9</p> <p>The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of QAI documents, it was determined the facility failed to ensure the QAI program monitored and analyzed patient data pertaining to treatment times, BFRs, and patient EDW goals in an effort to identify areas for improvement. This limited the facility's ability to correct deficiencies in patient care. Findings include:</p> <p>1. Review of QAI minutes showed that data was collected for patient outcomes addressed by the MAT, but no facility patient data for BFRs, cumulative loss of treatment times, or attaining EDWs was collected or analyzed.</p> <p>The lack of data collection and analysis led to the inability, by the facility, to prioritize areas for improvement and develop, implement, and evaluate plans that could have resulted in improvements in patient care.</p>	V 626	<p><i>Please see the attached documents</i></p> <p><i>Goals less than or equal to fifty days.</i></p>		

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V 626	Continued From page 10 In an interview on 7/12/12 at 9:00 AM, the nurse manager said the total number of missed treatments were tracked and trended for QAI purposes, but shortened treatments were not. She further stated no periodic audits were done to track or assess actual patient treatment data such as treatment time, BFR, or attained EDW, and no performance improvement activities had been initiated to identify areas of patient care that needed improvement. The facility failed to ensure an effective, data driven, quality assessment and performance improvement program was maintained to identify areas of patient care needing improvement.	V 626	<i>Please see the attached documents Goals less than or equal to sixty days.</i>		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an accurate medical record was maintained for 1 of 4 patients (Patient #1) whose medical records were reviewed. This failure led to the patient not receiving dialysis treatments as ordered by the physician. Findings include: 1. In an interview on 7/12/12 at 9:00 AM, the nurse manager explained the facility's EMR as	V 726			

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V 726	<p>Continued From page 11</p> <p>follows: The system, called ECube, was initiated at the facility in April, 2012, and included programs named Clinical and Chairside. Numerical information was exchanged between the two programs, but narrative information could not be exchanged. Chairside program information was printed as hard copy at the end of each treatment day and became the patients' permanent working record. Clinical program information was maintained in electronic format. An additional document, titled "HD Set Up Detail" was generated from Clinical program information and was used by staff in the actual delivery of patient treatments. This document was discarded at the end of each treatment day and was not maintained in patients' permanent records.</p> <p>Because notations in narrative form in the Clinical program did not transfer to the Chairside program, actual treatment data did not reflect Patient #1's treatment orders in the permanent record as follows:</p> <p>a. Patient #1 was a 34 year old male who had been dialyzing at the facility since 5/30/06. Eleven treatments, from 6/11/12 - 7/4/12, were reviewed for BFR. Patient #1 did not attain his prescribed BFR of 400 ml/min. during 11 of 11, or 100%, of treatments reviewed, leaving him at risk for complications of inadequate dialysis.</p> <p>b. Review of Patient #1's Clinical program information showed a notation under the heading "special attention." This notation stated it was Patient #1's preference to maintain his BFR at 350 ml/min. There was no corresponding physician's order. This information was</p>	V 726	<p><i>Please see the attached documents. Goals less than or equal to sixty days</i></p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/13/2012
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V 726	Continued From page 12 transposed to the HD Set Up Detail and staff set Patient #1's BFR at 350 ml/min. In an interview on 7/12/12 at 9:00 AM, the nurse manager said all narrative information needed to be entered into both the Chairside and Clinical programs in order for treatments to be delivered accurately. She confirmed that Patient #1's preferred BFR had been entered into the Clinical program but had not been entered into the Chairside program. She said this was redundant data entry that staff did not always have time to do. The facility failed to maintain a complete, accurate medical record for Patient #1.	V 726	<i>Please see the attached documents. Goals less than or equal to sixty days.</i>		

Post Falls Dialysis Unit
Plan of Correction
Date of Survey 07/13/2012

V116: 494.30(a)(1)(i)IC-IF TO STATION=DISP/DEDICATE OR DISINFECT

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure that supplies were dedicated for use on a single patient.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. On 07/17/12, all patient care staff was educated on the process to manage tape in the dialysis facility.
2. By 08/23/12, all patient care staff will participate in Infection Control education and training conducted by the Area Manager and Clinical Manager with an emphasis on management of dialysis supplies.
 - a. All patient care staff will review policy and procedure "Cleaning and Disinfection" (FMS-CS-IC-II-155-110A).
3. Any continuing deficiencies will result in implementation of the corrective action process with employees as appropriate. Identified deficiencies/ trends will require re-evaluation of the formal action plan in place, to be followed through until resolution.

Monitoring for continued compliance will be performed by utilizing the Quality Assessment and Improvement Infection Control audit daily times 2 weeks, weekly times one month, every other week times one month and monthly for three months by the Clinical Manager or designee beginning 08/24/12. Threshold for advancement of audits will be 100%.

Ongoing monitoring will occur through the scheduled QAI Infection Control audits per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all infection control audits and present to the QAI Committee for review and oversight. Monitoring of corrections will be discussed monthly with the Area Manager and Medical Director at the QAI meeting beginning August 2012 until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.

V403: 494.60(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure that a refrigerator was maintained in a manner appropriate for the storage of medications.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. On 07/13/12, affected medication was discarded.
2. On 07/13/12, the refrigerator was de-iced and cleaned.
3. On 07/18/12, a new refrigerator was placed in service.
4. By 08/23/12, all patient care staff will participate in staff meetings with a review of policy and procedures,
 - a. "Medication Preparation and Administration Policy (RCG-15-MM-2.08)

Monitoring for continued compliance will be performed by utilizing the Quality Assessment and Improvement Physical Environment audit monthly for 3 months beginning August 2012.

Ongoing monitoring for continued compliance will be performed by utilizing the QAI Physical Environment audit per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all audits and present to the QAI Committee for review and oversight. Monitoring of corrections will be discussed monthly with the Area Manager and Medical Director at the QAI meeting beginning August 2012 until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.

V463: 494.70(a)(12) PR-RECEIVE SERVICES OUTLINES IN POC

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's

failure to ensure that patients' rights to receive care as outlined in the Plan of Care were upheld.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. By 07/20/12, all staff was notified about the requirements to ensure patients are dialyzing per the physician prescription and/or documentation is found in the patient's medical record to explain the variance.
2. By 08/23/12, all patient care staff will participate in staff meetings with a review of policy and procedures,
 - a. "Monitoring the Patient During Hemodialysis" (9-HT-1.04)
 - b. Registered Nursing staff will review policy and procedure "Registered Nurse Responsibilities During Hemodialysis Treatment" (16-PC-1.03) and "Comprehensive Assessment and Plan of Care" (FMS-CS-IC-I-110-125A).
3. Beginning 08/24/12, the "Clinical Practice Supervision" tool will be utilized daily for each shift for 3 months and any patients not dialyzing as prescribed will be reviewed with the patient's physician and orders obtained.
4. Any continuing deficiencies will result in implementation of the corrective action process with employees as appropriate. Identified deficiencies/ trends will require re-evaluation of the formal action plan in place, to be followed through until resolution.

Monitoring for continued compliance will be performed by utilizing the daily Clinical Practice Supervision tool for three months. Additionally, a treatment sheet audit will be completed; 10% weekly times one month, 10% every other week times one month and monthly for three months by the Clinical Manager or designee beginning 08/24/12. Threshold for advancement of audits will be 100%.

Ongoing monitoring will occur through the scheduled QAI Medical Records audits per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all audits and present to the QAI Committee for review and oversight.

Monitoring of corrections will be discussed monthly with the Area Manager and Medical Director at the QAI meeting beginning August 2012 until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.

V562: 494.90(d) POC-PT/FAMILY EDUCATION & TRAINING

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure that periodic re-education was provided for patients.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. By 07/20/12, all staff was notified about the requirements to ensure documentation of patient and/or family education when patients are at potential risk for poor outcomes due to knowledge gaps.
2. By 08/23/12, all patient care staff will participate in staff meetings with a review of policy and procedures,
 - a. "Comprehensive Assessment and Plan of Care" (FMS-CS-IC-I-110-125A)
 - b. "Patient Education Policy" (FMS-CS-IC-I-101-007A)

Monitoring for continued compliance will be performed by utilizing the daily Clinical Practice Supervision tool for three months. Additionally, a treatment sheet audit will be completed; 10% weekly times one month, 10% every other week times one month and monthly for three months by the Clinical Manager or designee beginning 08/24/12. Threshold for advancement of audits will be 100%.

Ongoing monitoring will occur through the scheduled QAI Medical Records audits per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all audits and present to the QAI Committee for review and oversight.

Monitoring of corrections will be discussed monthly with the Area Manager and Medical Director at the QAI meeting beginning August 2012 until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.

V626: 494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure the QAI program monitored and analyzed patient data pertaining to treatment times, BFR's, and patient EDW goals in an effort to identify areas for improvement.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. Beginning 07/17/2012, data is being collected to review variances in patient data.
2. By 08/23/12, the Regional Quality Manager will meet with participants of the QAI committee for the purpose of reeducation on the QAI process related to patient treatment data monitoring, trending and process improvement activities. This education will include but not limited to the following:
 - a. "Quality Assessment and Performance Improvement Program" (FMS-CS-IC-I-101-001)
 - b. 2012 QAI Program, Tools and Minutes requirements
 - c. Analyzing, trending and development of action plans for unresolved issues
 - d. Reviewing mechanism for identification and correction of identified variances
3. By 08/23/12, the QAI committee will review the variances in patient data to analyze, determine trends and develop recommendations to minimize.

Ongoing monitoring will occur through the scheduled QAI Medical Records audits per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all audits and present to the QAI Committee for review and oversight. Monitoring will be discussed monthly with the Area Manager and Medical Director at the Quality Assessment and Improvement meeting beginning August 2012 and continuing until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.

V726: 494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE

On 07/16/12, in response to the Exit Interview of the survey, Area Manager met with the Clinical Manager, Regional Quality Manager and Regional Director of Education to discuss the findings and institute correction of the deficiency related to the facility's failure to ensure an accurate medical record was maintained.

Additionally, on 07/31/12, the Area Manager met with the Medical Director to discuss the CMS findings.

The deficiency will be corrected by:

1. By 08/23/12, all patient care staff will participate in staff meetings with a review of policy and procedures,
 - a. "Medication Record Documentation Standards" (FMS-CS-IC-II-150-030A)

Monitoring for continued compliance will be performed by a treatment sheet audit will be completed; 10% weekly times one month, 10% every other week times one month and monthly for three months by the Clinical Manager or designee beginning 08/24/12. Threshold for advancement of audits will be 100%.

Ongoing monitoring will occur through the scheduled QAI Medical Records audits per the calendar.

The Clinical Manager is responsible to review, analyze and trend the results of all audits and present to the QAI Committee for review and oversight. Monitoring will be discussed monthly with the Area Manager and Medical Director at the Quality Assessment and Improvement meeting beginning August 2012 and continuing until compliance has been established.

Meeting minutes will document the activity and will be available for review at the facility.