



IDAHO DEPARTMENT OF
HEALTH & WELFARE

CL. '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 208-334-6828
FAX 208-384-1888

November 25, 2011

Sue Pendlebury, Administrator
Gate City Dialysis Center
2001 Bench Road
Pocatello, ID 83201-2033

RECEIVED
NOV 27 2011
COMMUNITY HEALTH SERVICES

RE: Gate City Dialysis Center, Provider #132506

Dear Ms. Pendlebury:

This is to advise you of the findings of the Medicare survey of Gate City Dialysis Center, which was conducted on November 18, 2011.

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:

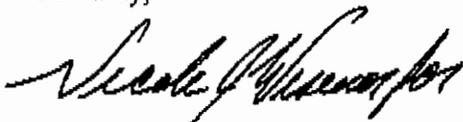
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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.

Sue Pendlebury, Administrator
November 25, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **December 8, 2011**, 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: 11/26/2011
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132506 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/18/2011 |
| NAME OF PROVIDER OR SUPPLIER GATE CITY DIALYSIS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 BENCH ROAD POCATELLO, ID 83201 | |
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| V 000 | INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the recertification survey was: Trish O'Hara, R.N., H.F.S. Acronyms used in the report include: AVF - Arteriovenous Fistula CVC - Central Venous Catheter kg - kilogram (2.2 pounds) ml - milliliter pH - measure of the acid/base properties of a liquid | V 000 | | |
| V 112 | 494.30(a) IC-CDC MMWR 2001 The facility must demonstrate that it follows standard infection control precautions by implementing- (1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call | V 112 | V 112 Plan: Teammates will be reeducated on P&P 1-04-01 and 1-05-01. Reminder cards were laminated and placed at the patient scale and at each patient chair, "Did you wash your access." Teammates were reeducated that if a patient refuses to wash their access when they come in for treatment, the teammate will wash it for them at chairside. An audit will be done along with the monthly infection control audit to insure that washing of accesses are being done. Timeline: Teammates will be required to read P&P 1-04-01 and 1-05-01 by December 6, 2011. The Laminated reminder cards will remain in place until goal is met that all access are wash prior to initiation of treatment. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Due Pendlebury, RN, FA

Facility Admin.

12-6-2011

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 112 | <p>Continued From page 1 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html.</p> <p>The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review it was determined the facility failed to provide infection control precautions for 4 of 4 patients (Patients #1, #7, #8, and #9), whose dialysis treatment initiation was observed using upper extremity accesses. This failure created the potential for access infections. Findings include:</p> <p>During an observation on 11/16/11 from 9:00 - 11:30 AM, Patients #1, #7, #8, and #9 were observed entering the treatment area of the facility for dialysis treatment. Inside the entry door was an area containing a scale and a sink. Patients #8 and #9 were escorted by staff members, and Patients #1 and #7 entered the treatment area unaccompanied. The four patients observed did not wash their upper extremity vascular access and proceeded to their assigned station for initiation of treatment.</p> <p>A facility policy titled "Infection Control For Dialysis Facilities," dated 9/2011, stated "Patients are encouraged to wash their hands and access</p> | V 112 | <p>Person Responsible: The RN FA is responsible for the audit, having the teammates read the two policies and placement of the reminder cards.</p> | 12/6/11 |

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| V 112 | <p>Continued From page 2</p> <p>extremity upon entering the treatment area prior to the initiation of dialysis...."</p> <p>In an interview on 11/17/11 at 1:30 PM, the Facility Administrator confirmed the policy and further stated it was facility practice for the nurse or patient care technician to wash the access extremity if the patient refused or was unable to wash it independently.</p> <p>The facility failed to implement measures to prevent infection through the washing of access extremities.</p> | V 112 | |
| V 113 | <p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review it was determined the facility failed to ensure the prevention of potential contamination for 1 of 2 patients (Patient #2), whose dialysis treatment termination was observed. Findings include:</p> <p>During an observation on 11/16/11 from 9:00 - 11:30 AM, Patient #2 was observed completing her dialysis treatment. Patient #2 dialyzed using an upper left extremity vascular access. After needle removal and dressing application, Patient #2 used her right index and middle fingers to apply pressure to her access to achieve</p> | V 113 | <p>V113 Plan: Patients will be educated on the need to wear gloves when holding their access. Teammates will be reeducated on the need for patients to wear gloves when holding their access. This will be monitored by FA's and Charge Nurses' direct observations.</p> <p>Timeline: Patients and Teammates will be educated on wearing gloves when holding the access site by December 6, 2011.</p> <p>Person Responsible: The RN FA is responsible to make sure that the Teammates and Patients receive the education.</p> <p>12/6/11</p> |

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| V 113 | Continued From page 3 hemostasis. However, she did not place a glove on her right hand prior to this procedure. Several minutes later, a nurse told her she was supposed to wear a glove while touching her access. A glove was applied at this time. Several minutes later, Patient #2 was observed removing the glove and leaving the treatment area. In an interview on 11/17/11 at 1:30 PM, the Facility Administrator said the patient should have worn a glove during the access holding procedure. A facility policy titled "Infection Control For Dialysis Facilities," dated 9/2011, stated "Gloves should be provided to patients and gloves and gowns to visitors if these individuals assist with procedures such as self cannulation or holding access sites." The facility failed to implement procedures to prevent transmission of infection. | V 113 | | |
| V 147 | 494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent Intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual | V 147 | V147 Plan: Teammates will be reeducated on P&P 1-04-12D. An audit will be done along with the monthly infection control audit to insure compliance. Timeline: All teammates will be reeducated on P&P 1-04-12D by December 6, 2011. Person Responsible: The RN FA is responsible to make sure that the Teammates read the P&P, and will audit compliance by observing care given by all teammates who initiate dialysis via a catheter. | 12/6/11 |

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| V 147 | <p>Continued From page 4</p> <p>patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview, and policy review it was determined the facility failed to ensure appropriate infection control measures were taken to prevent infections for 1 of 1 patients (Patient #5), who dialyzed using a central venous catheter. This directly impacted 1 patient and had the potential to impact all patients dialyzing with central venous catheters. This failure resulted in the potential for access acquired blood stream infections. Findings include:</p> <p>On 11/16/11 at 9:30 AM, termination of dialysis was observed for Patient #5. During this process, the nurse wrapped the connections between Patient #5's central venous catheter and the bloodlines with disinfectant soaked 4x4 gauze for 60 seconds. The gauze was removed and the</p> | V 147 | | | |

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| V 147 | Continued From page 5 connections were allowed to rest on a nonsterile disposable pad and Patient #5's personal blanket. The central venous catheter and bloodlines were then disconnected. A facility policy titled "Utilizing And Replacing Seven Day Needleless Silicone Connector Capping Device (Tego) For Central Venous Catheter (CVC) Care," dated 9/2011, gave step by step instructions for cleansing connections. The policy stated that after the connections were cleaned, the next step was to "Place sterile gauze pad under each limb of catheter." In an interview on 11/17/11 at 1:30 PM, the Facility Administrator confirmed the policy and stated sterility should have been maintained between cleansing the connections between the central venous catheter and the bloodlines and disconnecting. | V 147 | | |
| V 403 | 494.80(b) PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU The dialysis facility must implement and maintain a program to ensure that all equipment (including emergency equipment, dialysis machines and equipment, and the water treatment system) are maintained and operated in accordance with the manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on observation, staff interview, equipment log review, and manufacturer's recommendation review, it was determined the facility failed to | V 403 | V403 Plan: Audit equipment logs monthly, prior to end of day to insure that teammates are not signing logs prior to the maintance being done on the equipment. Timeline: All teammates will be educated on the signing of equipment logs and importance of when they are signed off by December 6, 2011. Person Responsible: The RN FA is responsible for education and audits to insure they are being signed off | 12/6/11 |

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| V 403 | <p>Continued From page 6</p> <p>ensure dialysate testing equipment was maintained in accordance with the manufacturer's recommendations. This failure had the potential to impact all patients at the facility by receiving dialysis treatment with inappropriate dialysate. Findings include:</p> <p>During an observation on 11/16/11 from 9:00 - 11:30 AM, the maintenance log for the facility's three pHOenix meters was reviewed. (These meters were used to test the pH, conductivity, and temperature of the dialysate prior to each patient's treatment.) The log was signed by a Licensed Practical Nurse, indicating the three meters had been disinfected, calibrated, cleaned, and prepared for overnight storage on 11/16/11. The meters were located and were still in use throughout the treatment floor.</p> <p>Mesa Laboratories, the manufacturer of the meters, provided directions for the maintenance of pHOenix meters in a technical note, dated 8/2009. This note recommended bleach disinfection and calibration prior to daily use. Additional maintenance included daily cleaning, at the end of each treatment day, with NeoStat and overnight storage with NeoStat and air in the meters and storage caps in place on the meters.</p> <p>In an interview on 11/16/11 at 10:00 AM, the Facility Administrator stated the pHOenix meter maintenance log should not have been signed before the actual care and maintenance was done on the meters.</p> <p>The facility failed to ensure equipment used to ensure patient safety was maintained according to manufacturer's recommendations.</p> | V 403 | | |

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| V 463 | <p>494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC</p> <p>The patient has the right to-</p> <p>(12) Receive the necessary services outlined in the patient plan of care described in §494.90;</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 patients received services as outlined in their care plans. This failure directly impacted 4 of 5 patients (Patient #1, #3, #4, and #5) whose treatment records were reviewed, and had the potential to impact all patients receiving dialysis treatments at the facility. This resulted in blood flow rates and/or estimated dry weights not being attained as prescribed. Findings include:</p> <p>1. Treatment records were reviewed for Patients #1, #3, #4, and #5 for treatment dates 10/17/11 - 11/14/11. These records showed documentation that all 4 patients were non-compliant with their dialysis times. The facility had addressed the issue with ongoing patient education. Given the documented non-compliance with treatment times, it was imperative the facility obtained prescribed blood flow rate/estimated dry weights to ensure adequacy of treatment. The treatment records reviewed documented concerns with blood flow rates and estimated dry weights as follows:</p> <p>a. Patient #1 was a 45 year old male who dialyzed at the facility using an upper extremity AVF. His dialysis prescription included an</p> | V 463 | <p>V 463 Plan: Create an audit to address the following issues:</p> <ol style="list-style-type: none"> 1. Was the patient on their correct Dialyzer? If not why? 2. What is the patient's prescribed EDW? Did they meet it? If not, why? Have they met it in the last 3 treatments? If not, do they need an adjustment to their EDW? 3. Did the patient treat for their prescribed treatment time? If not, why? 4. Did the patient run at their prescribed BFR? If not, why? Do they need an intervention? <p>Teamates will audit 2 charts weekly to make sure that we are following prescribed orders. The audits are then given RN FA for review. The RN FA will provide feedback to the team for teaching purposes as necessary.</p> <p>Timeline: 2 Treatment audits will be done each week, starting November 29, 2011, and will continue until goal is met, patients are treating on their prescribed treatment.</p> <p>Person Responsible: Clinical teammates to perform the audit, the RN FA to insure that audits are being done and to review the audits.</p> | 12/6/11 |

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| V 463 | <p>Continued From page 8</p> <p>ordered blood flow rate of 500 ml/minute for 258 minutes three times a week. Average blood flow rate was documented as:</p> <p>440 ml/minute on 10/21/11 467 ml/minute on 10/26/11 481 ml/minute on 10/31/11 483 ml/minute on 11/2/11 440 ml/minute on 11/7/11 478 ml/minute on 11/9/11</p> <p>This was a cumulative loss of 54.45 liters of blood processed during 6 treatments, a 7% loss of prescribed blood flow rate.</p> <p>There was no documentation in Patient #1's record explaining why prescribed blood flow rate was not attained.</p> <p>Additionally, Patient #1's estimated dry weight, his expected weight at the end of each treatment, was ordered to be 105 kg. His weight at end of treatment was documented as follows:</p> <p>10/17/11 - 107.5 kg 10/19/11 - 107.2 kg 10/21/11 - 107 kg 10/24/11 - 108 kg 10/26/11 - 109 kg 10/31/11 - 110.3 kg 11/2/11 - 108 kg 11/7/11 - 108.6 kg 11/9/11 - 106.4 kg 11/11/11 - 108 kg 11/14/11 - 107 kg</p> <p>There was no documentation in Patient #1's record explaining why prescribed dry weight was</p> | V 463 | | | |

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| V 463 | <p>Continued From page 9 not reached.</p> <p>b. Patient #3 was a 29 year old male who dialyzed at the facility using an upper extremity AVF. His dialysis prescription included an ordered blood flow rate of 550 ml/minute for 210 minutes three times a week. Average blood flow rate was documented as follows:</p> <p>470 ml/minute on 10/17/11 544 ml/minute on 10/19/11</p> <p>This was a cumulative loss of 18 liters of blood processed during 2 treatments, a loss of 8% of prescribed blood flow rate.</p> <p>There was no documentation in Patient #3's record explaining why prescribed blood flow rate was not attained.</p> <p>c. Patient #4 was a 67 year old male who dialyzed at the facility using an upper extremity AVF. His dialysis prescription included an ordered blood flow rate of 500 ml/minute for 210 minutes three times a week. Average blood flow rate was documented as follows:</p> <p>443 ml/minute on 10/21/11</p> <p>This resulted in a loss of 12 liters of blood processed during the treatment, a 12% loss of prescribed blood flow rate.</p> <p>There was no documentation in Patient #4's record explaining why prescribed blood flow rate was not attained.</p> <p>Additionally, Patient #4's estimated dry weight</p> | V 463 | | |

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| 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 11/18/2011 |
|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER GATE CITY DIALYSIS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 BENCH ROAD POCATELLO, ID 83201 | |
| (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 463 | <p>Continued From page 10</p> <p>was ordered to be 60.5 kg. His weight at end of treatment was documented as follows:</p> <p>10/24/11 - 63 kg 11/2/11 - 67 kg 11/4/11 - 65.7 kg 11/14/11 - 69.8 kg</p> <p>There was no documentation in Patient #4's record explaining why prescribed dry weight was not reached.</p> <p>Further, Patient #4's estimated dry weight was increased on his dialysis prescription, on 11/4/11 from 60.5 kg to 70 kg, an increase of 21 pounds. A progress note by the facility's nurse practitioner, dated 11/4/11, stated "2+ edema in lower extremities. Fluid volume overload. Continue current plan of care."</p> <p>In an interview on 11/17/11 at 1:00 PM, the nurse practitioner said she had not changed Patient #4's estimated dry weight on 11/4/11.</p> <p>In an interview on 11/17/11 at 1:30 PM, the Facility Administrator stated the computer software had automatically deleted Patient #4's estimated dry weight because he had missed 3 treatments. She explained a staff nurse had re-entered Patient #4's estimated dry weight incorrectly on his prescription.</p> <p>d. Patient #5 was a 20 year old female who dialyzed at the facility with an upper extremity AVF until 11/5/11, and then with a CVC. Her dialysis prescription, on 10/26/11, included an ordered blood flow rate of 500 ml/minute for 210 minutes three times a week. Average blood flow</p> | V 463 | | |

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: 132506 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/18/2011 | |
|---|---|---|---|----------------------|
| NAME OF PROVIDER OR SUPPLIER GATE CITY DIALYSIS CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 BENCH ROAD POCATELLO, ID 83201 | | |
| (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 463 | <p>Continued From page 11 rate was documented as follows:</p> <p>468 ml/minute on 10/26/11 368 ml/minute on 10/31/11 450 ml/minute on 11/9/11</p> <p>Patient #5's prescription was changed, on 11/11/11, to a blood flow rate of 450 ml/minute. Average blood flow rate on 11/14/11 was documented as follows:</p> <p>440 ml/minute</p> <p>This was a cumulative loss of 47 liters of blood processed during 4 treatments, a 12% loss of prescribed blood flow rate.</p> <p>There was no documentation in Patient #5's record explaining why prescribed blood flow rate was not reached.</p> <p>Additionally, Patient #5's estimated dry weight was ordered to be 64.5 kg. Her weight at end of treatment was documented as follows:</p> <p>66.4 kg on 10/17/11 65.8 kg on 10/21/11</p> <p>The prescribed weight was changed, on 10/24/11, to 65 kg. Patient #5's weight at end of treatment was documented as follows:</p> <p>66.9 kg on 11/9/11 67.6 kg on 11/11/11 65.9 kg on 11/14/11</p> <p>There was no documentation in Patient #5's record explaining why prescribed dry weight was</p> | V 463 | | |

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: 132506 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 11/18/2011 | |
|---|---|---|---|----------------------|
| NAME OF PROVIDER OR SUPPLIER GATE CITY DIALYSIS CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 BENCH ROAD POCATELLO, ID 83201 | | |
| (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 463 | <p>Continued From page 12 not reached.</p> <p>In an interview on 11/17/11 at 1:30 PM, the Facility Administrator confirmed the variances from prescriptions found in the patients' treatment records reviewed. She said all dialysis treatments should have been provided according to the patients' prescriptions.</p> <p>In an interview on 11/17/11 from 10:00 - 11:05 AM, the facility's Medical Director confirmed adequacy of dialysis was decreased in patients who were fluid overloaded.</p> <p>The facility failed to ensure patient adequacy was maintained through the provision of services outlined in plans of care.</p> | V 463 | | |