IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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November 15, 2018

Larry Kelley, Administrator
Burley Dialysis Center
741 North Overland Avenue
Burley, ID 83318-2106

RE: Burley Dialysis Center, Provider #132503

Dear Mr. Kelley:

Based on the survey completed at Burley Dialysis Center, on November 2, 2018, by our staff, we have determined Burley Dialysis Center is out of compliance with the Medicare ESRD Condition for Coverage of **QAPI - Indicator-Medical Injuries / Errors (42 CFR 494.110)**. To participate as a provider of services in the Medicare Program, an ESRD must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Burley Dialysis Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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 each form.

Such corrections must be achieved and compliance verified by this office, before December 17, 2018. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 2, 2018.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 27, 2018**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

PRINTED: 11/14/2018
FORM APPROVED
OMB NO. 0938-0391

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
	132503	A. BUILDING _____ B. WING _____	11/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLEY DIALYSIS CENTER	741 NORTH OVERLAND AVENUE BURLEY, ID 83318

(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 10/29/18 - 11/01/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: AMA - Against Medical Advice AOR - Adverse Occurrence Report AVG - Arteriovenous Graft BP - Blood Pressure c/o - complains of CVC - Central Venous Catheter FA - Facility Administrator ICHD - Incenter Hemodialysis kg - kilogram MD - Medical Doctor ml - milliliter PCT - Patient Care Technician QAPI - Quality Assurance Performance Improvement RN - Registered Nurse tx - treatment TW - Target Weight UFR - Ultrafiltration Rate	V 000		
V 403	PE-EQUIPMENT MAINTENANCE-MANUFACTURER'S DFU CFR(s): 494.60(b) 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	V 403		

RECEIVED
NOV 27 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary T. Keller RN — TITLE: Facility Administrator — (X6) DATE: 11-27-2018

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

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V 403	Continued From page 1 manufacturer's recommendations. This STANDARD is not met as evidenced by: Based on staff interview, equipment log review and policy review, it was determined the facility failed to ensure disinfection, according to facility policy, was maintained for 6 of 15 dialysis machines (machines #5 - #11) whose disinfection records were reviewed. This failure had the potential to impact all patients at the facility by receiving dialysis treatments with potentially contaminated equipment. Findings include: The facility used 15 Fresenius 2008K dialysis machines to perform hemodialysis treatments for 36 patients. Policy 2-02-01 titled Fresenius Dialysis Delivery System Cleaning And Disinfection Policy, dated October 2017, stated all dialysis machines were to be disinfected with bleach or peracetic acid weekly and verifying logs were to be completed. The facility disinfected dialysis machines each Wednesday evening after patient treatments were completed. Review of the current Dialysis Delivery System Clean and Disinfect Log showed on Wednesday, 10/31/18, only 8 of the 15 machines had been disinfected with bleach as required. Machines #5 - #11 showed a routine heat disinfect. Machine #15 showed both heat and bleach disinfection. In a telephone interview on 11/01/18 at 10:00 A.M., the technician who initialed the log said all machines had been disinfected with bleach the prior evening. She said she had filled out the log	V 403	V403 The FA in-serviced 100% of clinical teammates on 11/19/2018 and 11/21/2018 on policy 2-02-01 Fresenius Dialysis Delivery System Cleaning and Disinfection Policy. Emphasis on notification that bleach was done on the machine by a sign and teammate initials on log. Evidence of training was accomplished using a training sign in sheet. FA or designee will complete weekly disinfectant audits, focusing on all spaces filled in with initials. Teammates failing to follow policy and procedure will be counseled. Weekly audits will be completed on 100% of disinfect logs until 100% compliance is achieved, after which time disinfectant audits will be completed monthly as part of the facility's infection control audit, target compliance 100%. FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	12/2/18

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V 403	Continued From page 2 incorrectly. In the same interview, the FA confirmed the information on the disinfect log and agreed it would not be possible to ensure all machines had been appropriately disinfected. Six dialysis machines were not disinfected according to facility policy.	V 403		
V 643	POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1) The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on standing order and policy review, staff interview, and clinical record review, it was determined the facility failed to ensure episodes of abnormal blood pressure were addressed and that patients' fluid was managed during each treatment for 4 of 5 ICHD patients (Patients #1 - #4) whose treatment records were reviewed. This resulted in the potential for patients to experience complications due to fluid overload between dialysis treatments and complications from hypertension and hypotension. The findings include: 1. Fluid was not managed as follows: Corporate policy 1-03-08 titled PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT, revised April 2017, stated	V 643	V543 The FA in-serviced 100% of clinical teammates on 11/15/2018 on FluidWise management, communication on the floor, hypotensive episodes and FluidWise focus reporting and on policy 1-03-08 Pre-Intra-Post Treatment Data collection, Monitoring and Nursing Assessment with an emphasis on RN notification of the physician as needed. Evidence of training was accomplished using a training sign in sheet. FA or designee will complete weekly post treatment audits, focusing on Target Weight and response to hypotensive events and falcon intervention from the IDT team. The Facility Standing Order has been revised to indicate "Additional day of dialysis if patient has symptoms of fluid overload, or > 1 kg over target weight. Teammates failing to follow policy and procedure will be counseled. Daily audits will be completed on 20 flow sheets x 1 week, then weekly audits will be completed on 21 flowsheets x 1 week. Ongoing compliance will be monitored with the monthly 10% medical records audit. FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	12/2/18

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V 543	Continued From page 3 "...unless other abnormal parameters are established by the facility Governing Body...the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record." Post-treatment weight was defined as abnormal if it was "above or below 1 kg from the target weight." Standing Orders for Burley Dialysis, revised 3/20/18, stated "Additional day of dialysis if patient has symptoms of fluid overload, or is significantly over TW." Significantly was not defined. - Patient #1 was a 69 year old female. Her dialysis prescription included a TW of 70 kg from 9/28/18 - 10/07/18. TW was increased to 70.5 kg on 10/08/18. TW was increased to 71 kg on 10/17/18. Patient #1's post dialysis weight was > 1 kg above her TW as follows: - On 10/01/18 by 1.5 kg. - On 10/03/18 by 1.4 kg. - On 10/05/18 by 1.6 kg. - On 10/08/18 by 1.7 kg. - On 10/15/18 by 2.1 kg. - On 10/22/18 by 1.1 kg. - On 10/24/18 by 1.0 kg. - On 10/26/18 by 1.6 kg. There was no documentation the weight differences were reported to or were addressed by the licensed nurse. In an interview on 10/30/18 at 11:00 A.M., the FA said the discrepancy may have been due to the	V 543		

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V 543	Continued From page 4 additional weight of a transfer sling not being removed. - Patient #2 was a 60 year old male. His dialysis prescription included a TW of 75 kg. His post dialysis weight was >1 kg above his TW as follows: - On 10/03/18 by 2.1 kg. - On 10/08/18 by 1.6 kg. - On 10/15/18 by 1.8 kg. There was no documentation the weight differences were reported to or were addressed by the licensed nurse. - Patient #3 was a 30 year old female. Her dialysis prescription included a TW of 46 kg. Her post dialysis weight was >1 kg above her TW as follows: - On 10/01/18 by 1.7 kg. - On 10/05/18 by 1.9 kg. There was no documentation the weight differences were reported to or were addressed by the licensed nurse. - Patient #4 was an 86 year old male. His dialysis prescription included a TW of 78.5 kg. His post dialysis weight was >1 kg above his TW on 10/01/18 by 1.5 kg. There was no documentation the weight difference was reported to or was addressed by the licensed nurse.	V 543		

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V 543	Continued From page 5 In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the unaddressed weight differences for Patients #1 - #4. Fluid was not managed per standing orders for Patients #1 - #4. 2. Hypertension was not addressed as follows: Standing Orders for Burley Dialysis, revised 3/20/18, defined hypertension as "Systolic BP >/= 200 and/or diastolic BP >/= 100." Ordered interventions included increasing dialysate temperature and checking patient blood pressure every 15 minutes. The orders also stated, "Patient may not leave the treatment floor with systolic BP > 200 without MD order." - Patient #2 was a 60 year old male. His intradialytic hypertension was not monitored every 15 minutes during 4 of 11 treatments reviewed. On 10/03/18 at 8:04 A.M. his BP was 205/91. It was not checked again until 8:28 A.M. On 10/05/18 at 8:04 A.M. his BP was 225/106. It was not checked again for 31 minutes. On 10/22/18 at 6:04 A.M. his BP was 209/95. The next check was at 6:34 A.M. At 7:04 A.M. his BP was 207/99. The next 30 minute check, at 7:34 A.M. showed a BP of 202/92. The next 30 minute check, at 8:05 A.M. showed a BP of 205/96. The next 30 minute check, at 8:34 A.M. showed a	V 543		

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V 543	Continued From page 6 BP of 207/93. At this time the PCT documented "Turned off due to eyesight." The next 30 minute check, at 9:04 A.M. showed a BP of 206/93. Patient #2's treatment was ended at 9:06 A.M. with a BP reading of 203/94. The nurse's post assessment did not address Patient #2's hypertension or his "eyesight" complaint. On 10/26/18 at 7:04 A.M. Patient #2's BP was 202/96. The next 30 minute check, at 7:35 A.M. showed BP at 210/97. The next check was done at 8:05 A.M. Additionally, Patient #2 left the treatment floor after 5 of 11 treatments, from 9/28/18 - 10/29/18, with a systolic BP reading> 200 and no documented MD orders. On 10/01/18 his post treatment BP reading was 201/93. On 10/05/18 his post treatment BP reading was 214/91. On 10/10/18 his post treatment BP reading was 207/97. On 10/22/18 his post treatment BP reading was 203/94. On 10/26/18 his post treatment BP reading was 201/96. No MD orders were found for these dates showing the physician was aware of Patient #2's post treatment hypertension or had released him.	V 543		

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V 543	Continued From page 7 There was no documentation of interventions for Patient #2's hypertensive episodes. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the facility's standing orders for hypertension had not been followed for Patient #2. Hypertension was not monitored as prescribed for Patient #2. 3. Hypotension was not addressed as follows: Standing Orders for Burley Dialysis, revised 3/20/18, defined hypotension as "Systolic BP >/= 90 and/or diastolic </= 50." Ordered interventions for hypotension included 100 ml saline bolus, decreased dialysate temperature, application of oxygen per nasal cannula, and checking the BP every 15 minutes. - Patient #3 was an 86 year old male. His intradialytic hypotension was not monitored every 15 minutes during 11 of 14 treatments reviewed from 9/28/18 - 10/29/18. BP was monitored every 30 minutes with an average diastolic reading consistently below 50 as follows: 9/28/18 - average diastolic BP 38. At the end of treatment Patient #3 fell at the scale, hitting his head on the wall. He refused transport by EMT. 10/03/18 - average diastolic BP 38. 10/05/18 - average diastolic BP 45. 10/08/18 - average diastolic BP 46. 10/12/18 - average diastolic BP 44. 10/15/18 - average diastolic BP 45. 10/17/18 - average diastolic BP 41. 10/19/18 - average diastolic BP 44.	V 543		

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V 543	Continued From page 8 10/22/18 - average diastolic BP 39. 10/24/18 - average diastolic BP 37. 10/26/18 - average diastolic BP 46. There was no documentation of interventions for Patient #3's hypotensive episodes. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the facility's standing orders for hypotension had not been followed for Patient #3. Hypotension was not monitored as prescribed for Patient #3.	V 543	V544	
V 544	POC-ACHIEVE ADEQUATE CLEARANCE CFR(s): 494.90(a)(1) Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each patient's prescribed dose of dialysis was delivered as ordered and shortened treatment times were addressed. This directly impacted 4 of 5 ICHD patients (Patients #1, #2, #4, and #5) whose treatment records were reviewed, and had the potential to impact all patients dialyzing at the facility, by placing them at risk of decreased adequacy. The findings include: Prescribed treatment times were not delivered as follows:	V 544	The FA in-serviced 100% of clinical teammates on 11/19/2018 and 11/21/2018 on North Star Prescription Verification and Safety Checks, 1-01-09 Shortened/Early Termination of treatment or Extended Treatment, and 1-01-09A Early Termination of Treatment Against Medical Advice (AMA) Form. Evidence of training was accomplished using a training sign in sheet. FA or designee will complete weekly post treatment audits, focusing on shortened treatment times and proper documentation in SNAPPY, Falcon, and AMA's. Teammates failing to follow policy and procedure will be counseled. Daily audits will be completed on 20 flow sheets x 1 week, then weekly audits will be completed on 21 flowsheets x 1 week. Ongoing compliance will be monitored with the monthly 10% medical records audit. FA will review results of audits during monthly PHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	12/2/18

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V 544	Continued From page 9 - Patient #1 was a 69 year old female. Her dialysis prescription included a treatment time of 180 minutes 3 times a week. On 9/28/18 her treatment was shortened by 15 minutes with a nursing note stating "per pt request." On 10/01/18 her treatment was shortened by 19 minutes with a PCT note stating "Pt c/o not feeling well. RN said take her off tx." On 10/08/18 her treatment was shortened by 8 minutes with no reason documented. On 10/19/18 her treatment was shortened by 21 minutes due to a verified blood leak and required machine change. There were no AMA forms documenting Patient #1 was offered the opportunity to make up the time lost during the 4 events. - Patient #2 was a 60 year old male. His dialysis prescription included a treatment time of 195 minutes 3 times a week. On 9/28/18 his treatment was shortened by 14 minutes with no documented reason. On 10/05/18 his treatment was shortened by 18 minutes with no documented reason. On 10/08/18 his treatment was shortened by 2 minutes with no documented reason. On 10/12/18 no treatment was given. On 10/17/18 no treatment was given.	V 544		

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V 544	Continued From page 10 There were no AMA forms documenting Patient #2 was offered the opportunity to make up the time lost during the 5 events. - Patienty #4 was a 30 year old female. Her dialysis prescription included a treatment time of 180 minutes 3 times a week. On 10/15/18 her treatment was shortened by 9 minutes with a nursing note stating "Pt not feeling well." On 10/22/18 her treatment was shortened by 5 minutes with no documented reason. There were no AMA forms documenting Patient #4 was offered the opportunity to make up the time lost during the 2 events. - Patient #5 was a 31 year old male. His dialysis prescription included a treatment time of 225 minutes 3 times a week. On 10/19/18 his treatment was shortened by 10 minutes with a nursing note stating "Treatment terminated. Pt clotted." There was no AMA form documenting Patient #5 was offered the opportunity to make up the time lost during the event. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the lost treatment time for Patients #1, #2, #4, and #5 and the lack of AMA documentation. Prescribed treatment time was not provided for 4 patients and opportunities to make up lost time	V 544		

PRINTED: 11/14/2018
FORM APPROVED
OMB NO. 0938-0391

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
	132503	A. BUILDING _____ B. WING _____	11/02/2018

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V 544	Continued From page 11 were not offered.	V 544		
V 625	CFC-QAPI CFR(s): 494.110 This CONDITION is not met as evidenced by: Based on staff interview, AOR data review, treatment record review, and QAPI meeting minute review, it was determined the facility failed to ensure a QAPI program was maintained that accurately collected data affecting patients' outcomes. This failure allowed for problems to remain unidentified and uncorrected and patient outcomes to remain unimproved. The findings include: 1. Refer to V634 as it relates to the facility's failure to ensure data pertaining to medication and treatment errors was accurately collected for review.	V 625	V625 Members of the Governing Body (GB) have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standards under Conditions of QAPI (V625), as well as other standards, contain specifics of corrective plans. The Governing Body will meet weekly to ensure compliance with the POC. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi- annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC. Refer to V634	12/2/18
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 adverse occurrence reports review, AOR tracking log review, treatment sheet review, and staff interview, it was determined the facility failed to ensure data related to adverse occurrences was accurately collected. This failure directly impacted 5 of 6 ICHD patients	V 634		

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V 634	Continued From page 12 (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 by 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 AOR tracking form listed 84 events for which data was to be collected for review by the QAPI committee. These events included treatment errors (treatments not delivered as prescribed), AMAs (used for shortened treatments), blood loss, hypertension, hypotension, and medication errors. A review of facility QAPI meeting minutes from 1/2018 - 9/2018 showed the QAPI committee reviewed facility data, including data related to adverse occurrences, and based process changes and action plans on the data received and reviewed. The facility's records did not include documentation that AORs had been consistently completed for review by the QAPI committee, as follows: 1. Medication errors, treatment errors, and blood loss were not identified as follows: a. Patient #1 was a 69 year old female who dialyzed for 3 hours, using either her CVC or her AVG. i. Her dialysis prescription included Heparin to be infused at 400 units/hour. When the AVG was used, Heparin was ordered to be discontinued 60 minutes before the end of treatment, for a total of	V 634	V634 We respectfully disagree with this citation as it relates to the requirement for the completion of an AOR for all shortened treatments. Policy 13-01-02 (attached) #9 – "An AOR is not required for patients who miss or shorten their treatment. However, the missed or shortened treatment should be noted in the patient's medical record and a facility AMA should be completed and signed by the patients for shortened treatments." In our review of the conditions for coverage, we were unable to identify guidance addressing shortened treatments or the need to complete adverse occurrences. The facility does recognize the need for improved documentation for shortened treatments and the need for care plans to be completed for patients who have a pattern of shortening or missing treatments. The FA or designee will inservice the Interdisciplinary Team on policy 1-14-06 Continuous Quality Improvement Program by 12/2/18. Evidence of training will be accomplished using a training sign in sheet. The IDT will be instructed to review missed treatments and to develop plans for improvement as needed. Daily audits will be completed on 20 flow sheets x 1 week, then weekly audits will be completed on 21 flowsheets x 1 week. Flowsheet review will focus on complete documentation and obtaining an AMA for all shortened treatments. The FA/designee will complete a review of care plans monthly to ensure that all patients with a pattern of shortening or missing treatments have an unstable care plan completed. Ongoing compliance will be monitored with V634 cont on page 14	12/2/18

PRINTED: 11/14/2018
FORM APPROVED
OMB NO. 0938-0391

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

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	132502	A. BUILDING _____ B. WING _____	11/02/2018

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V 634	Continued From page 13 800 units/treatment. When the CVC was used, Heparin was to be discontinued at the end of treatment, for a total of 1200 units/treatment. On 10/22/18 Patient #1's CVC was used for treatment. However, Heparin was discontinued before the end of treatment as evidenced by a Heparin charge for 800 units and a machine reading of 1000 units. On 10/29/18 Patient #1's AVG was used for treatment. However, Heparin was not discontinued 60 minutes before the end of treatment as evidenced by a Heparin charge for 1500 units and a machine reading of 1500 units. No AORs were documented for the medication errors. ii. On 10/19/18 nursing notes stated "blood leak identified. Tx paused, no rinseback performed." There was no AOR documented for the blood loss due to dialyzer blood leak that had occurred. iii. A process called UF only, where fluid is removed but waste is not removed, could be accomplished with the dialysis machine by stopping dialysate flow. On 10/08/18 Patient #1 had an MD order for "UF 1 hr at begin of tx goal 2.5 then reg tx" for a total of 240 minutes. Patient #1's treatment sheet documented the following: - UF was not performed for the first hour as evidenced by documented dialysate flow of 600 ml/minute for the first 43 minutes of treatment.	V 634	V634 Continued from page 13 the monthly 10% medical records audit. The Clinical Services Specialist will attend QAPI for the next 3 months to provide oversight of QAPI processes and to ensure thorough documentation with a focus on missed/ shortened treatments. FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring, and ongoing compliance with this plan of correction.	12/2/18

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V 634	Continued From page 14 - UF was not completed for the prescribed 60 minutes as evidenced by a nurse's note at the 43 minute point stating "Pt not feeling well. Stopped UF and started tx." - Total treatment time was 232 minutes rather than the ordered 240 minutes. - Total Heparin infused was documented in separate places on the treatment sheet as 800 units given and 1200 units given. Both doses were signed off by the PCT. AORs were not completed for the 4 treatment and medication errors that occurred during Patient #1's treatment. b. Patient #2 was a 60 year old male. His dialysis prescription ordered a TW of 75 kg. On 10/03/18 Patient #2's pre treatment weight was 76.7 kg. His post treatment weight was 77.1 kg. A pre treatment nursing note stated "Treatment initiated...Goal 2 kg" to be removed. However, the machine UFR, as documented on the treatment sheet, was set at .06 for the entire treatment, removing only 60 ml of fluid. A post treatment nursing assessment did not address the lack of fluid removal. There was no AOR documented for the treatment error. c. Patient #4 was a 30 year old female. She dialyzed for 180 minutes and her dialysis prescription included an order for a Heparin infusion rate of 1000 units/hour, to be discontinued 60 minutes before the end of treatment, for a total of 2000 units.	V 634		

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V 634	Continued From page 15 On 10/01/18 a PCT noted no Heparin had been given during the treatment because the "Heparin pump wasn't turned on." There was no AOR documented for the medication error. d. Patient #5 was a 31 year old male whose dialysis prescription ordered treatment time of 225 minutes. On 10/19/18 treatment was ended 10 minutes early with a PCT note stating "Treatment terminated. Pt clotted." No further documentation was present and an RN post assessment did not address the clotting episode. There was no AOR documented for the clotted system/dialyzer or accompanying blood loss. In an interview on 10/18/18 at 1:00 P.M., the FA confirmed the medication errors, treatment errors, and blood loss had not been documented on the October 2018 AOR log for Patients #1, #2, #4, and #5. 2. Prescribed target weights were not met as follows: Corporate policy 1-03-08 titled PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT, revised April 2017, stated "...unless other abnormal parameters are established by the facility Governing Body...the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record."	V 634		

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V 634	Continued From page 16 Post-treatment weight was defined as abnormal if it was "above or below 1 kg from the target weight." Standing Orders for Burley Dialysis, revised 3/20/18, stated "Additional day of dialysis if patient has symptoms of fluid overload, or is significantly over TW." Significantly was not defined. a. Patient #1's dialysis prescription included a TW of 70 kg from 9/28/18 - 10/07/18. TW was increased to 70.5 kg on 10/08/18. TW was increased to 71 kg on 10/17/18. Patient #1's post dialysis weight was > 1 kg above her TW on 10/01/18, 10/03/18, 10/05/18, 10/08/18, 10/15/18, 10/22/18, 10/24/18, and on 10/26/18. b. Patient #2's dialysis prescription included a TW of 75 kg. Patient #2's post dialysis weight was >1 kg above his TW on 10/03/18, 10/08/18 and on 10/15/18. c. Patient #3's dialysis prescription included a TW of 46 kg. Patient #3's post dialysis weight was >1 kg above her TW on 10/01/18 and on 10/05/18 by 1.9 kg. d. Patient #4's dialysis prescription included a TW of 78.5 kg. Patient #4's post dialysis weight was >1 kg above his TW on 10/01/18. There were no AORs completed for treatment errors on the dates Patients #1 - #4 did not attain TW +/- 1 kg as prescribed. In an interview on 11/01/18 at 9:00 A.M., the FA	V 634		

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V 634	Continued From page 17 confirmed the unaddressed weight differences for Patients #1 - #4 and confirmed AORs had not been completed for the treatment errors. 3. Hypertension was not addressed as follows: Standing Orders for Burley Dialysis, revised 3/20/18, defined hypertension as "Systolic BP >/= 200 and/or diastolic BP >/= 100." Ordered interventions included increasing dialysate temperature and checking patient blood pressure every 15 minutes. The orders also stated, "Patient may not leave the treatment floor with systolic BP > 200 without MD order." Patient #2's intradialytic hypertension was not monitored every 15 minutes during 4 of 11 treatments reviewed. a. On 10/03/18 at 8:04 A.M. his BP was 205/91. It was not checked again until 8:28 A.M. b. On 10/05/18 at 8:04 A.M. his BP was 225/106. It was not checked again for 31 minutes. c. On 10/22/18 at 6:04 A.M. his BP was 209/95. The next check was at 6:34 A.M. At 7:04 A.M. his BP was 207/99. The next 30 minute check, at 7:34 A.M. showed a BP of 202/92. The next 30 minute check, at 8:05 A.M. showed a BP of 205/96. The next 30 minute check, at 8:34 A.M. showed a BP of 207/93. At this time the PCT documented "Turned off due to eyesight."	V 634		

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FORM APPROVED
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V 634	Continued From page 18 The next 30 minute check, at 9:04 A.M. showed a BP of 206/93. Patient #2's treatment was ended at 9:06 A.M. with a BP reading of 203/94. The nurse's post assessment did not address Patient #2's hypertension or his "eyesight" complaint. d. On 10/26/18 at 7:04 A.M. Patient #2's BP was 202/96. The next 30 minute check, at 7:35 A.M. showed BP at 210/97. The next check was done at 8:05 A.M. Additionally, Patient #2 left the treatment floor after 5 of 11 treatments, from 9/28/18 - 10/29/18, with a systolic BP reading > 200. No MD orders were found for 5 treatments showing the physician was aware of Patient #2's post treatment hypertension or had released him. There were no AORs documented for Patient #2's hypertensive episodes or his post treatment hypertension. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the facility's standing orders for hypertension had not been followed for Patient #2 and no AORs had been documented. 4. Hypotension was not addressed as follows: Standing Orders for Burley Dialysis, revised 3/20/18, defined hypotension as "Systolic BP >/= 90 and/or diastolic </= 50." Ordered interventions for hypotension included 100 ml saline bolus, decreased dialysate temperature, application of oxygen per nasal cannula, and checking the BP every 15 minutes.	V 634		

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V 634	Continued From page 19 Patient #3's intradialytic hypotension was not monitored every 15 minutes during 11 of 14 treatments reviewed from 9/28/18 - 10/29/18. BP was monitored every 30 minutes with an average diastolic reading consistently below 50 as follows: 9/28/18 - average diastolic BP 38. At the end of treatment Patient #3 fell at the scale, hitting his head on the wall. He refused transport by EMT. 10/03/18 - average diastolic BP 38. 10/05/18 - average diastolic BP 45. 10/08/18 - average diastolic BP 46. 10/12/18 - average diastolic BP 44. 10/15/18 - average diastolic BP 45. 10/17/18 - average diastolic BP 41. 10/19/18 - average diastolic BP 44. 10/22/18 - average diastolic BP 39. 10/24/18 - average diastolic BP 37. 10/26/18 - average diastolic BP 46. There was no documentation of interventions for Patient #3's hypotensive episodes. There were no AORs documented for Patient #3's hypotensive episodes. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the facility's standing orders for hypotension had not been followed for Patient #3 and AORs had not been documented. 5. Prescribed treatment times were not delivered as follows: a. Patient #1's dialysis prescription included a treatment time of 180 minutes 3 times a week. i. On 9/28/18 her treatment was shortened by 15 minutes with a nursing note stating "per pt	V 634		

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V 634	Continued From page 20 request." ii. On 10/01/18 her treatment was shortened by 19 minutes with a nursing note stating "Pt c/o not feeling well. RN said take her off tx." iii. On 10/08/18 her treatment was shortened by 8 minutes with no reason documented. iv. On 10/19/18 her treatment was shortened by 21 minutes due to a verified blood leak and required machine change. There were no AMA forms and therefore no AORs, documenting time lost during the 4 events. b. Patient #2 was a 60 year old male. His dialysis prescription included a treatment time of 195 minutes 3 times a week. i. On 9/28/18 his treatment was shortened by 14 minutes with no documented reason. ii. On 10/05/18 his treatment was shortened by 18 minutes with no documented reason. iii. On 10/08/18 his treatment was shortened by 2 minutes with no documented reason. iv. On 10/12/18 no treatment was given. v. On 10/17/18 no treatment was given. There were no AMA forms and therefore no AORs, documenting time lost during the 5 events. c. Patient #4 was a 30 year old female. Her dialysis prescription included a treatment time of 180 minutes 3 times a week.	V 634		

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V 634	Continued From page 21 i. On 10/15/18 her treatment was shortened by 9 minutes with a nursing note stating "Pt not feeling well." ii. On 10/22/18 her treatment was shortened by 5 minutes with no documented reason. There were no AMA forms and therefore no AORs, documenting time lost during the 2 events. d. Patient #5 was a 31 year old male. His dialysis prescription included a treatment time of 225 minutes 3 times a week. On 10/19/18 his treatment was shortened by 10 minutes with a nursing note stating "Treatment terminated. Pt clotted." There was no AMA form and therefore no AOR, documenting the time lost during the event. In an interview on 11/01/18 at 9:00 A.M., the FA confirmed the lost treatment time for Patients #1, #2, #4, and #5 and the lack of AMA and AOR documentation. Accurate AOR data was not collected and provided to the QAPI committee for review and remedial action.	V 634		

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E 000	Initial Comments No deficiencies were cited during the recertification of your facility, from 10/29/18 - 11/01/18, for Emergency Preparedness. Burley Dialysis Center is in compliance with the requirements of CFR 494.62. The surveyor conducting the survey was: Trish O'Hara RN	E 000		

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.