IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 8, 2015

Amanda Hayvaz, Administrator
Moscow Dialysis Center
212 Rodeo Drive, Suite 110
Moscow, ID 83843

RE: Moscow Dialysis Center, Provider #132521

Dear Ms. Hayvaz:

This is to advise you of the findings of the Medicare survey of Moscow Dialysis Center, which was conducted on March 26, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **April 21, 2015,** 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/pmt
Enclosures

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

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132521	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSCOW DIALYSIS CENTER	212 RODEO DRIVE, SUITE 110 MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 3/23/15 - 3/26/15. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: APD - Automated Peritoneal Dialysis IV - Intravenous ml - milliliter PD - Peritoneal Dialysis RN - Registered Nurse	V 000	V000 The Governing Body (GB) of Moscow Dialysis has reviewed the Statement of Deficiency resulting from the Recertification survey completed on March 26, 2015. The GB has developed, approved and respectfully submits the following plan of correction. RECEIVED APR 14 2015 FACILITY STANDARDS	
V 587	494.100(b)(2),(3) H-FAC RECEIVE/REVIEW PT RECORDS Q 2 MONTHS The dialysis facility must - (2) Retrieve and review complete self-monitoring data and other information from self-care patients or their designated caregiver(s) at least every 2 months; and (3) Maintain this information in the patient ' s medical record. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure home hemodialysis treatment records were reviewed to ensure prescribed treatment was self administered for 1 of 1 patients (Patient #1) receiving home dialysis. This resulted in a patient not receiving medications as prescribed. Findings include: Patient #1 was a 42 year old male who had been dialyzing at the facility, utilizing home	V 587	V587 The Home Program RN has reviewed the medication orders for patient #1 and included a review of all patients on Home Hemodialysis (HHD) therapy. Orders have been verified with patients' physician, updated, and noted in patient's medical records as necessary. Patient #1 Re-educated on 3/25/15 during their clinic visit on requirement to complete all aspects of flow sheet accurately during their home treatment. Also re-educated to bring all flow sheets for the month to the monthly clinic visit for review by HHD RN. Patient was also educated on importance of following prescribed treatment and documenting correctly on flow sheets during the clinic visit on 3/25/15. All other patients identified with any medication inaccuracies during reviews will be provided re- education on correct medication orders and accurate documentation on daily flow sheets.	

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

[signature], Facility Administrator, April 13 2015

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 587	Continued From page 1 hemodialysis as his modality, since 7/26/11. a. His prescription included a current order, dated 12/30/14, for Heparin (an anticoagulant drug), 4500 units to be given IV push 5 minutes prior to the onset of each treatment. Thirty treatment sheets were reviewed from 12/30/14 - 2/11/15. Documentation signed by the patient showed Heparin 4000 units had been given prior to 1 treatment, and Heparin 6000 units had been given prior to 25 treatments. The treatment sheets had been signed by the RN indicating she had reviewed their content. A more recent order for a change in Heparin dosage could not be located. The nurse, who no longer worked at the facility, was contacted by telephone on 3/24/15 at 5:00 p.m. She said she did not recall if Patient #1's Heparin dose had been changed or when a dose change might have taken place. In an interview on 3/26/15 at 5:30 p.m., the Home Program Manager confirmed the variances in Heparin dosage. She said the different doses should have been noted during the RN review. b. Patient #1's prescription also contained an order, dated 12/16/14, for Epogen (an anti anemia drug) 6600 units to be given IV push three times a week. Review of thirty treatment sheets from 12/30/14 - 2/11/15 showed Epogen had only been given one time during the period reviewed. On 1/7/15 6000	V 587	This education will be documented in patient's medical record. On 3/25/15 the Home Program Manager completed RN Training and e-educated on requirement for patient to bring in flow sheets to monthly clinic visit for review by RN. The following topics were reviewed: RN reviews must include prescribed medication documentation. If inaccuracies are identified during flow sheet reviews, the RN will verify MD orders and re-educate the patient via telephone or clinic visit. Documentation will reflect patient education. To prevent re-occurrence, the HHD RN and FA will audit 100% flow sheet review monthly times 3 months. Audits will be conducted for April, May and June. Then 10% flow sheet audits will continue monthly. Results will be reported in monthly QAPI meeting. FA is responsible for this poc.	4/26/15

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V 587	Continued From page 2 units was administered as indicated by Patient #1's signature. In an interview on 3/25/15 at 5:30 p.m., the Home Program Manager confirmed missing Epogen doses. She said the lack of documented doses should have been noted and addressed during the RN review. Patient #1's treatment sheets were not reviewed to ensure treatments were administered as prescribed.	V 587		
V 597	494.100(c)(1)(vi) H-PROVIDE ORDERED SUPPLIES/EQUIPMENT Services include, but are not limited to, the following: (vi) Purchasing, leasing, renting, delivering, installing, repairing and maintaining medically necessary home dialysis supplies and equipment (including supportive equipment) prescribed by the attending physician. This STANDARD is not met as evidenced by: Based on patient grievance and treatment record review and staff interview, it was determined the facility failed to ensure dialysis supplies were provided for 1 of 1 PD patients (Patient #2) whose records were reviewed. This failure directly resulted in a patient experiencing increased fluid retention, which placed him at risk of complications of excessive fluid. Findings include: Patient #2 was a 50 year old male who had been dialyzing at the facility since 10/13/10. He currently utilized APD as his modality. His	V 597	V597 The FA and/or Home Program Manager will meet with Patient #2 identified during survey to review the patient complaint and utilize grievance process to resolve. During the week of 4/13/15, the FA has reviewed the following process with the Home patient care team: Renewing Formulary Exception approvals will be as follows: Calendar reminder using Outlook added to both FA and PD RN calendars for and repeating annually to renew Formulary Exception approval. Patient charts with formulary exception (FE) orders will be flagged with a neon sticker that a FE renewal is due annually in December. Baxter contacted January 19, 2015 and given updated email contact information for FA and PD RN. FA will contact Baxter on 3/27/15 to verify the correct email facility contact information has been received and is currently correct. FA will monitor compliance by auditing FE patients monthly x 3 months, then quarterly. Audits will include a visual observation of neon sticker and that FE orders have been placed and followed through with company and vendor. Patient complaints and FE process audits will be reviewed in monthly QAPI meetings. FA is responsible for this poc.	4/26/15

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V 597	Continued From page 3 dialysis prescription included five 3000 ml cycles during each nightly twelve hour treatment, with a final fill of Extraneal to dwell during the daytime hours. This final fill was drained, being recorded as "initial drain," by Patient #2 prior to him connecting to his cycler for treatment each night. The manufacturer's website, www.Baxter.com, described Extraneal as a peritoneal dialysis solution designed to improve fluid and waste removal in peraons with certain peritoneal membrane characteristics. Aooording to a 2/16/15 patient grievance, Patient #2 did not receive a shipment of Extraneal, scheduled for delivery on 1/19/15 from the supplier, leaving him without the prescribed solution for treatments from 1/24/15 - 1/28/15. Review of treatment records for the month of January, 2015 showed Patient #2's average daily initial drain amount was 1334 ml when Extraneal was used. Average initial drain amount on the 5 days that Extraneal was not available was recorded as 48 ml, a difference of 1286 ml per day that was not removed from Patient #2. In an interview on 3/25/15 at 4:00 p.m., the PD nurse confirmed the incident had occurred. She said prior to the incident she had not been aware that Extraneal was a non formulary prescription that required renewal and corporate approval each January. She said by the time she was made aware, contacted the supplier, renewed the prescription, and waited for corporate approval, Patient #2 had run out of solution. The facility failed to supply Patient #2 with supplies needed for treatment.	V 597		

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