IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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May 18, 2015

Michelle Hurst, Administrator
Liberty Dialysis Nampa
280 West Georgia Avenue
Nampa, ID 83686

RE: Liberty Dialysis Nampa, Provider #132516

Dear Ms. Hurst:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Nampa, which was conducted on May 5, 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 **May 31, 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

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132516	A. BUILDING _____ B. WING _____	05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS NAMPA	280 WEST GEORGIA AVENUE NAMPA, ID 83686

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 4/27/15 - 5/5/15. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: B/P - Blood Pressure bpm - beats per minute EDW - Estimated Dry Weight kg - kilogram ml - milliliter mm/hg - millimeters of mercury (a measure of blood pressure) NS - normal saline POC- Plan of Care PRN - As needed UF - ultrafiltration	V 000	RECEIVED JUN - 1 2015 FACILITY STANDARDS	
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS 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 record review and staff interview, it was determined the facility failed to ensure blood pressure and volume status was appropriately managed for 6 of 6 patients (Patients #1 - #6) whose POCs and treatment sheets were reviewed. This resulted in the potential for patients to experience unaddressed changes in condition during dialysis treatments and	V 543		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: RN, BSN Clinic Manager (X6) DATE: 5/26/15

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 543	Continued From page 1 complications of fluid overload. The findings include: 1. Routine monitoring of vital signs every thirty minutes was not consistently implemented for Patients #1 - #6. The facility's "Determination of Blood Pressure" policy, date 7/4/12 stated B/P readings were to be obtained every 30 minutes...". Additionally, patients' dialysis treatment orders were documented on a Hemodialysis Annual Physician Orders, signed by the physician. This order set stated "Vital signs every 1/2 hour..." during treatment. This document was present in the medical records of Patients #1 - #6. However the facility policy and treatment orders were not consistently implemented as follows: a. Patient #1 was a 54 year old female who had been dialyzing at the facility since 1/15/11. Fifteen treatment records were reviewed from 3/28/15 - 4/28/15. Six of fifteen treatment sheets showed vital signs had not been taken every 30 minutes as follows: - 4/4/15 from 5:48 a.m. until 6:43 a.m. - 4/7/15 from 5:46 a.m. until 6:28 a.m., at which time her blood pressure had decreased from 197/90 to 98/53. - 4/14/15 from 5:45 a.m. until 6:31 a.m., at which time her blood pressure had decreased from 149/110 to 93/53. - 4/16/15 from 8:04 a.m. until 9:02 a.m.	V 543		

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V 543	Continued From page 2 - 4/23/15 from 5:41 a.m. until 6:31 a.m., at which time her blood pressure had decreased from 187/120 to 95/90. - 4/28/15 from 7:34 a.m. until 8:37 a.m. b. Patient #2 was a 52 year old female who had been dialyzing at the facility since 6/25/13. Thirteen treatment records from 3/30/15 - 4/27/15 were reviewed. Five of thirteen treatment records showed vital signs had not been taken every 30 minutes as follows: - 4/1/15 from 2:05 p.m. until 3:15 p.m. - 4/3/15 from 12:04 p.m. until 1:02 p.m., and again from 2:01 p.m. until 3:09 p.m. - 4/15/15 from 2:06 p.m. until the end of treatment at 3:05 p.m. - 4/22/15 from 2:00 p.m. until the end of treatment at 3:05 p.m. - 4/24/15 from 1:01 p.m. until the end of treatment at 3:04 p.m. c. Patient #3 was a 41 year old female who had been dialyzing at the facility since 12/15/14. Eleven treatment records were reviewed from 3/31/15 - 4/25/15. Four of eleven treatments records showed vital signs had not been taken every 30 minutes as follows: - 4/7/15 from 12:30 p.m. until 1:31 p.m. - 4/9/15 from 12:33 p.m. until 1:19 p.m.	V 543		

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V 543	Continued From page 3 - 4/21/15 from 1:01 p.m. until 2:04 p.m. - 4/25/15 from 1:00 p.m. until 2:12 p.m. d. Patient #4 was a 76 year old male who had been dialyzing at the facility since 1/31/15. Eleven treatment records were reviewed from 3/28/15 - 4/25/15. Six of eleven treatment records showed vital signs had not been taken every 30 minutes as follows: - 3/28/15 from 1:06 p.m. until 2:03 p.m. - 4/7/15 no vital signs were taken at the initiation of treatment at 5:57 a.m. until 6:33 a.m. - 4/9/15 from 1:31 p.m. until 2:38 p.m. - 4/18/15 from 7:32 a.m. until 8:34 a.m. and again from 8:34 a.m. until 9:31 a.m. - 4/23/15 from 7:10 a.m. until 8:38 a.m. and again from 8:38 a.m. until 9:31 a.m. - 4/25/15 from 5:57 a.m. until 7:04 a.m. and again from 8:02 a.m. until 9:03 a.m. e. Patient #5 was a 46 year old male patient who had dialyzed at the facility since 3/21/15. Thirteen records were reviewed from 3/28/15 - 4/25/15. Four of thirteen treatment records showed vital signs had not been taken every 30 minutes as follows: - 4/7/15 no vital signs were taken at the initiation of treatment at 5:57 a.m. until 6:33 a.m. - 4/28/15 from 7:32 a.m. until 8:34 a.m. and again from 8:34 a.m. until 9:31	V 543		

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V 543	Continued From page 4 a.m. - 4/23/15 from 7:10 a.m. until 8:38 a.m. and again from 8:38 a.m. until 9:31 a.m. - 4/25/15 from 5:57 a.m. until 7:04 a.m. and again from 8:02 a.m. until 9:03 a.m. f. Patient #6 was a 71 year old female patient who had been dialyzing incenter since 7/15/14. Sixteen treatment records were reviewed from 3/30/15 - 4/27/15. Two of sixteen treatment records showed vital signs had not been on a routine basis as follows: - 4/6/15 from 8:03 a.m. until 9:01 a.m. - 4/25/15 no vital signs were taken at the initiation of treatment at 2:33 p.m. until 3:20 p.m. In an interview on 4/30/15 at 3:00 p.m., the clinical manager confirmed the missed monitoring opportunities for Patients #1 - #6 and said vitals should have been taken at least every 30 minutes during the patients' treatments. 2. Increased monitoring was not implemented for Patients #1 and #3 when the need was indicated by nursing notes. A "Determination of Blood Pressure" policy, date 7/4/12 stated B/P readings were to be obtained every 30 minutes or more during hemodialysis, post treatment, and as needed." The policy did not define what "as needed" meant. Patients' dialysis treatment orders were documented on a Hemodialysis Annual Physician Orders form, signed by the physician. This order	V 543		

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V 543	Continued From page 5 set stated "Vital signs every 1/2 hour and more frequently prn" during treatment. The order did not define what "prn" meant. The facility's Nursing Supervision and Delegation policy, dated 9/25/13, said the charge nurse would use his/her clinical judgement based on individual patient needs to determine if any clinical interventions were necessary for "B/P less than or equal to 100 mm/hg systolic during treatment." Patient #1 and #3's records showed increased monitoring was determined by the nurse to be necessary. However, the increased monitoring was not documented, as follows: a. Patient #1 was a 54 year old female who had been dialyzing at the facility since 1/15/11. Fifteen treatment records were reviewed from 3/28/15 - 4/28/15. Documentation showed increased levels of monitoring were not performed as follows: On 3/31/15 Patient #1 was experiencing a symptomatic episode of hypotension with a blood pressure of 87/52. At 6:32 a.m. nursing notes said another reading would be taken in 15 minutes. However, a follow up blood pressure was not taken for 32 minutes, at 7:04 a.m. During the same treatment on 3/31/15 at 8:02 a.m. her B/P remained low and staff documented her blood pressure would be monitored again in 15 minutes. However, blood pressure was not monitored until 33 minutes later, at 8:35 a.m. On 4/2/15 Patient #1 experienced a hypotensive event with a B/P decrease from 157/74 to 88/53	V 543		

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V 543	Continued From page 6 at 6:33 a.m. Staff documented her B/P would be rechecked in 15 minutes. However, Patient #1's B/P was not rechecked for 33 minutes, at 7:06 a.m. On 4/9/15 at 6:06 a.m. Patient #1's B/P had decreased from an initial reading of 184/95 to 98/63 at 6:06 a.m. Nursing notes stated another reading would be taken in 15 minutes. However, another reading was not taken for 27 minutes, at 6:33 a.m. On 4/11/15 Patient #1's B/P had decreased from an initial reading of 175/92 to 89/50 at 3:32 p.m. Nursing notes stated "recheck in 15 minutes." However, her B/P was not rechecked for 29 minutes, at 4:01 p.m. On 4/16/15 Patient #1's B/P had decreased from an initial reading of 185/101 to 93/68 at 6:31 a.m. Nursing notes stated "recheck in 15 minutes." However, another B/P reading was not taken for 31 minutes, at 7:01 a.m. At this time Patient #1's B/P remained low at 90/38. Again nursing notes stated "recheck in 15 minutes." Patient #1's B/P was not rechecked for 30 minutes, at 7:31 a.m. On 4/25/15 Patient #1's B/P had decreased from an initial reading of 239/100 to 88/50 at 7:02 a.m. Nursing notes stated "BP low, recheck in 15 minutes." However, her B/P was not rechecked for 29 minutes, at 7:31 a.m. b. Patient #3 was a 41 year old female who had been dialyzing at the facility since 12/15/14. Eleven treatment records were reviewed from 3/31/15 - 4/25/15. Documentation showed increased levels of monitoring were not performed as follows:	V 543		

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V 543	Continued From page 7 On 3/31/15 Patient #3's B/P had decreased from 155/95 at 12:30 p.m. to 81/56 at 1:00 p.m. Nursing documentation said "recheck BP in 15 minutes." However, Patient #3's B/P was not rechecked for 29 minutes, at 1:29 p.m. In an interview on 4/30/15 at 3:00 p.m., the Clinical Manager confirmed the missed follow ups. She said if a follow up was determined by the nurse to be necessary it should have been done. Increased monitoring was not performed as needed for Patients #1 and #3. 3. The facility did not implement consistent prn B/P monitoring. The facility's policies related to B/P monitoring were reviewed. The Nursing Supervision and Delegation policy, dated 9/25/13, stated the nurse was to be notified "If B/P less than or equal to 100 mm/hg systolic during treatment." The nurse would then determine appropriate interventions. A corresponding "Determination of Blood Pressure" policy, date 7/4/12 stated B/P readings were to be obtained every 30 minutes or more during hemodialysis, post treatment and as needed." The policy did not define what "as needed" meant. The Hemodialysis Annual Physician Orders form stated "Vital signs every 1/2 hour and more frequently prn" during treatment. However, information related to what would trigger prn B/P monitoring was not included in the medical records.	V 543		

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V 543	Continued From page 8 In an interview on 4/30/15 at 2:00 p.m., the medical director stated hypotension was not defined in facility policy and no specific blood pressure parameters were used facility wide because each patient's expectation was different. However, Patients #1 and #3's POCs did not include individualized parameters for intradialytic blood pressure readings indicating what level of blood pressure would present a danger to the patients in the form of decreased tissue and organ perfusion, and no staff guidance for more aggressive treatment to maintain perfusion was present. Additionally, while the facility's hypotensive protocol, dated 1/28/15, stated patients who experienced hypotensive symptoms were to be monitored and their B/P was to be recorded "at least every five minutes until any symptoms related to hypotension have been relieved," the policy did not include information related to prn monitoring expectation for patients who experienced asymptomatic hypotensive episodes. Neither the facility's policies nor the patient's POCs included information related to prn B/P monitoring for patients who experienced asymptomatic hypotensive episodes. Further, patient records did not included documentation that prn monitoring was consistently implemented for episodes of hypotension, as follows: a. Patient #1 was a 54 year old female who had been dialyzing at the facility since 1/15/11. Fifteen treatment records were reviewed from	V 543		

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V 543	Continued From page 9 3/28/15 - 4/28/15. Her records did not document consistent implementation of prn monitoring. Examples included, but were not limited to, the following: i. 4/7/15: Patient #1's B/P was not checked from 5:46 a.m. until 6:28 a.m., at which time her blood pressure had decreased from 197/90 to 73/44. Her record documented B/P was rechecked, as follows: - 6:31 a.m. (3 minutes later) 98/53. Interventions, including UF being turned off and 100 mL of NS were initiated. - 7:06 a.m. (35 minutes later) 79/47. No additional interventions were initiated and Patient #1 stated she felt a little dizzy. However, Patient #1 was not monitored "at least every five minutes until any symptoms related to hypotension have been relieved" per facility policy. - 7:35 a.m. (29 minutes later) 103/53. Patient #1's UF was turned back on. - 7:47 a.m. (12 minutes later) 95/55. - 8:31 a.m. (44 minutes later) 104/49. - 8:49 a.m. (18 minutes later) 85/45. A note stated Patient #1 was alert and denies complaint. "Patient is hypotensive...100 mL NS." The records documented Patient #1 was to be monitored every 15 minutes, which occurred during the last 40 minutes of her treatment. ii. 3/31/15: Patient #1's B/P was not checked from 5:41 a.m. until 6:31 a.m., at which time her blood pressure had decreased from 169/78 to 87/52.	V 543		

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V 543	Continued From page 10 Her UF rate was turned off and 100 ml NS was given. Nursing notes said B/P would be rechecked in 15 minutes. Her record documented B/P was rechecked, as follows: - 7:04 a.m. (32 minutes later) 73/40. 200 ml of NS was given. - 7:31 a.m. (27 minutes later) 114/52. UF rate was turned back on. - 7:37 a.m. (6 minutes later) 97/44. UF rate was turned off. Patient #1 said she was warm and feeling dizzy. However, Patient #1 was not monitored "at least every five minutes until any symptoms related to hypotension have been relieved" per facility policy. - 8:02 a.m. (25 minutes later) 110/57. UF rate was turned on. A note stated "B/P increased recheck in 15 minutes." - 8:35 a.m. (33 minutes later) 122/62. A note stated Patient #1 was resting comfortably. Patient #1's record did not include consistent prn monitoring of her hypotensive episodes. b. Patient #3 was a 41 year old female who had been dialyzing at the facility since 12/15/14. Eleven treatment records were reviewed from 3/31/15 - 4/25/15. Her records did not document consistent implementation of prn monitoring. Examples included, but were not limited to, the following: i. 4/7/15: Patient #3's pre dialysis standing B/P was 161/135 and sitting B/P was 84/64 with a pulse rate of 41 bpm. Treatment was initiated at	V 543		

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V 543	Continued From page 11 11:20 a.m. with a B/P reading of 84/60. Her record documented B/P was rechecked, as follows: - 11:30 a.m. (9 minutes later) 80/54. No interventions were documented. - 12:00 p.m. (30 minutes later) 80/56. 200 ml of NS was given and a note stated B/P would be rechecked in 15 minutes. - 12:15 p.m. (15 minutes later) 83/57. 500 ml NS was given. - 12:32 p.m. (17 minutes later) 155/95. A note said UF rate was turned off because B/P was falling. Recheck B/P in 15 minutes. -1:00 p.m. 81/56 (29 minutes later) 81/56. No interventions were documented. - 1:29 p.m. (29 minutes later)79/51. No interventions were documented. - 2:01 p.m. (32 minutes later) 91/59. No interventions were documented. - 2:30 p.m. (29 minutes later) 93/60. No interventions were documented. - 2:43 p.m. Post dialysis sitting B/P was 100/63. Standing B/P was marked as "cannot assess" although a note said Patient #3 "ambulated out of the unit." Patient #3's record did not include consistent prn monitoring of her hypotensive episodes. In an interview on 4/30/15 at 3:00 p.m., the	V 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132516	A. BUILDING _____ B. WING _____	05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS NAMPA	280 WEST GEORGIA AVENUE NAMPA, ID 83686

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V 543	Continued From page 12 clinical manager confirmed prn monitoring was not consistently implemented for Patients #1 and #3. 4. Patient's did not attain prescribed EDW during treatments and documentation showing determination of cause or plans to correct the issues were not present. In an interview on 4/29/15 at 2:30 p.m., the Medical Director said his expectation was for patients' post dialysis weight to be within 1 kg of their prescribed EDW. He stated if the goal was not met he would expect a plan to attain the goal would be devised. a. Patient #1 was a 54 year old female who had been dialyzing at the facility since 1/15/11. Her prescribed EDW was 114.5 kg. Fifteen treatment records were reviewed from 3/28/15 - 4/28/15. Weight variations were not addressed, as follows: 3/31/15: Post weight was 115.8 kg. 4/7/15: Post weight was 116.9 kg. 4/16/15: Post weight was 115.7 kg. Patient #1's record did not include documentation determining the cause or planning for correction of the excess weight for the above listed dates. Additionally, on 4/28/15, Patient #1's pre dialysis weight was 113.6 kg. Fluid removal was recorded as 1.6 kg and post weight was 114.7 kg. There was no documentation explaining the weight discrepancy. b. Patient #2 was a 52 year old female who had	V 543		

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V 543	Continued From page 13 been dialyzing at the facility since 6/25/13. Her EDW was prescribed at 60.5 kg and was increased to 62.5 kg on 4/20/15. Thirteen treatment records from 3/30/15 - 4/27/15 were reviewed. Weight variations were not addressed, as follows: 4/15/15: Post weight was 62.9 kg. 4/17/15: Post weight was 62.3 kg. 4/24/15: Post weight was 63.8 kg. Patient #2's record did not include documentation determining the cause or planning for correction of the excess weight for the above listed dates. c. Patient #3 was a 41 year old female who had been dialyzing at the facility since 12/15/14. Her prescribed EDW was 34.5 kg. On 4/14/15 it was decreased to 31.5 kg and on 4/16/15 it was increased to 32.5 kg. Eleven treatment records were reviewed from 3/31/15 - 4/25/15. Weight variations were not addressed, as follows: 4/7/15: Pre dialysis weight was 34.8 kg. Fluid removed was recorded as 0.6 kg. Post weight was 32.9 kg. No documentation was present explaining the weight variation. 4/9/15: Pre dialysis weight was 31.5 kg. Fluid removed was recorded as 0.0 kg. Post weight was 31.7 kg. No documentation was present explaining the weight variation and Patient #3's EDW was decreased to 31.5 kg. 4/14/15: Pre dialysis weight was 34.3 kg. A net 0.5 kg of fluid was removed. Post was noted to be 34.4 kg, 2.9 kg above EDW. No	V 543		

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V 543	Continued From page 14 documentation was present explaining the weight variation and Patient #3's EDW was increased to 32.5 kg. 4/16/15: Post dialysis weight was 34.5 kg, 2 kg above EDW. No documentation was present determining the cause and Patient #3's EDW was increased to 34.0 kg. 4/23/15: Pre dialysis weight was 37.4 kg. Fluid removal was recorded as 1.2 kg. Post weight was 34.2 kg, 2 kg less than calculated. No documentation was present explaining the weight variation. d. Patient #5 was a 46 year old male patient who had dialyzed at the facility since 3/21/15. His prescribed EDW was 89.0 kg. Thirteen records were reviewed from 3/28/15 - 4/25/15. Weight variations were not addressed, as follows: 3/31/15: Post weight was 90.9 kg. 4/4/15: Post weight was 91.8 kg. 4/7/15: Post weight was 91.2 kg. 4/11/15: Post weight was 91.9 kg. 4/14/15: Post weight was 90.9 kg. Patient #5's record did not include documentation determining the cause or planning for correction of the excess weight for the above listed dates. In an interview on 4/30/15 at 3:00 p.m., the Clinical Manager confirmed the lack of documentation concerning patients not attaining post dialysis weights within 1 kg of prescribed	V 543		

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V 543	Continued From page 15 EDW. She said nursing staff should have determined the cause for and a plan to correct weights that were out of parameters. Failure to reach prescribed EDW was not identified and corrected.	V 543		

ACTION PLAN

Project Leader: C.M. Michelle Hurst, RN, BSN	**Medical Director Name:** Christopher Keller	**Project Start Date:** 4/1/2015
BU/Region/Area/Facility/Location #: West/Great Plains/ Rocky Mountain/Nampa 7426		
Contact phone: 208-463-8558		

Opportunity Statement: Plan of care and management of patient's fluid volume status	**Goal** : Ensure the POC addresses individual patient needs regarding fluid management and blood pressure; patient blood pressure is addressed per policy while on treatment; and descrepency between UF on the machine and weight on the scale is decreased or eliminated entirely.

Root Causes: Education deficit with the staff regarding policy and procedure, machine use and how blood pressure is downloaded from machine to patient record, error in how patient food and drink is added into patient goal or documented into patient UF goal, RN education on how to individualize plan of care to each patient.

Team Members: All Facility's Staff

ACTION STEP (PDCA)	PERSON RESPONSIBLE	ESTIMATED COMPLETION DATE	DATE COMPLETED	FOLLOW UP (results, outcomes, observations, trend data)

1. Blood pressure is to be monitored on each patient at a minimum of every 30 minutes and then documented appropriately. a. CM will audit 10% of the patient's treatment record's weekly for 2 months to ensure timely and accurate documentation. Audit results will be tracked on a spread sheet and taken to QAI. Should this not show improvement through evaluation in QAI, more frequent audits will be implemented. b. CM will review the Determination of Blood Pressure Policy and Procedure FMS-CS-IC-I-110-134C with direct patient care staff c. CM will review Complications of Hemodialysis – Management and Prevention of Hypotension policy IC-II-125-006A, IS-I-515-025A and procedure with direct patient care staff	CM, RN, PCT	8/1/2015		
2. Plan of Care a. CM will educate RN's on how to add indivulaization to the care plans including but not limited to blood pressure management, fluid volume status, and how to identify a normal range for a patient based on an order from a physician. b. CM will work with Regional Quality Manager to do continued education with RN's regarding assessment and documentation on indivudalization of the plan of care regarding patient fluid volume status and blood pressure in terms of what is normal for these patients	CM, RN, RQM	8/1/2015 *extended in order to coordinate with RQM education schedule		

3. Excess weight in relation to the UF setting on the dialysis machine a. All saline prime and rinse back will be added to the patients goal and documented into the machine as well as chairside b. All fluids brought into the clinic to be consumed by the patient will be added into the patient goal and documented into the machine as well as chairside c. Staff will be present at all patient pre and post weights in order to ensure accuracy and consistency of measurement. Any discrepancy will be documented in either the multidisciplinary notes in chairside or the nursing notes in eCube Clinicals	RN, PCT, All DPC	7/15/2015		