IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

July 7, 2015

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

RE: Burley Dialysis Center, Provider #132503

Dear Mr. Kelley:

This is to advise you of the findings of the Medicare survey of Burley Dialysis Center, which was conducted on June 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 **July 20, 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

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

PRINTED: 07/02/2015
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
	132503	A. BUILDING _____ B. WING _____	06/26/2015

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 of your ESRD facility from 6/22/15 - 6/25/15. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AOR - Adverse Occurrence Report BFR - Blood Flow Rate CVC - Central Venous Catheter EDW - Estimated Dry Weight FA - Facility Administrator ICHD - Incenter Hemodialysis IDT - Interdisciplinary Team K - Potassium kg - kilogram L - Liter MD - Medical Doctor mEq/L - milequivalent per liter ml - milliliter POC - Plan of Care QAPI - Quality Assurance Performance Improvement RN - Registered Nurse UF - Ultrafiltration (fluid removal)	V 000	V000 The Governing Body (GB) of Burley Dialysis has reviewed the Recertification Statement of Deficiency. The GB has developed, approved and respectfully submit the following plan of correction. RECEIVED JUL 15 2015 FACILITY STANDARDS	
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90;	V 463	V 463 The FA in-serviced clinical teammates 06/24/15 on policy #3-02-02: Medical Record Preparation and Charting Guidance, policy 3-01-07A: Patient Rights. The FA in-serviced teammates 07/07/15 on policy 1-03-18: Use of Low Potassium Dialysate, policy 3-02-03: Orders For Patient Care, policy 3-02-10: Physician Order Policy, and DaVita education courses: "Legal Aspects of Documentation", "Documentation Basic Training", "Documentation-Chair Side Snappy" and "SMART Documentation". Teammates were instructed on: Continued on next page	

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

Tony T. Keller — FACILITY ADMINISTRATOR — 7-15-15

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.

PRINTED: 07/02/2015
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
	132603	A. BUILDING _____ B. WING _____	06/26/2015

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 463	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure patients' right to receive care as outlined in their POCs was upheld for 3 of 4 ICHD patients (Patients #1, #2 and #3) whose records were reviewed. This resulted in a patient being put at risk of complications from decreased serum potassium levels, and patients being put at risk of inadequate dialysis and complications from low BFR. Findings include: 1. A policy titled Use Of Low Potassium Dialysate, dated 9/2013, stated "Use of low potassium dialysate less than 2K is restricted to the patient with a pre-dialysis potassium level greater than 6 mEq/L... Patients with orders for <2K dialysate will have follow-up pre-dialysis serum potassium levels checked weekly... If follow-up pre-dialysis serum potassium level is < 6 mEq/L, RN will contact MD for appropriate order changes prior to next treatment." Patient #1 was a 41 year old male who dialyzed at the facility three times a week. A serum potassium level, drawn on 6/8/15, showed a result of 6.9 mEq/L for Patient #1 and, per policy, his dialysate was changed to a 1K beginning treatment on 6/10/15. On 6/12/15, his physician wrote an order stating serum potassium levels should be obtained weekly for Patient #1 and he should dialyze on a 1K dialysate if his potassium was greater than 5.5 mEq/L. A serum potassium was drawn on 6/15/15 with a result of 5.4 mEq/L.	V 463	1. All aspects of proper documentation to include rationale for variations to treatment prescription and the notification of the physician when such variations occur. 2. The importance of following physician orders and communication when unable to do so. 3. The use of low potassium dialysate in the clinic to include but not limited to possible negative outcomes. Patient #1's dialysate was changed per physician order and has been properly adjusted each treatment per physician order. Patients #2 & #3 BFR have been maintained at the prescribed level, or proper documentation has been completed for any variations and the physician has been notified of these variations. The Charge nurse is performing daily audits using the "Charge Nurse Daily Audit Form" to insure that all patients are receiving their prescribed treatment specific to prescribed potassium dialysate bath and prescribed BFR. These audits will continue for 90 days and will be reviewed by the Medical director during the monthly QAPI with an improvement plan developed if needed. The FA will monitor treatments through the use of the "Post Treatment tool" to insure the patients are receiving their prescribed treatment. This audit will be conducted daily for all patients for 2 weeks, 30 % of patients for 2 weeks and 10% of patients quarterly thereafter. These audits will be reviewed by the Medical director during the monthly QAPI with an improvement plan developed if needed. The FA is responsible for compliance.	7/20/15

PRINTED: 07/02/2015
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 _____	06/26/2015

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 463	Continued From page 2 However, a review of four treatment sheets, from 6/15/15 - 6/22/15, showed Patient #1 continued to dialyze using a 1K dialysate when his serum potassium level was below 5.5 mEq/L. There was no documentation showing his physician had been notified of the 6/15/15 potassium value or why Patient #1 continued to dialyze on a 1K dialysate. In an interview on 6/23/15 at 2:00 p.m., the FA confirmed Patient #1's dialysate had not been changed when it should have been. The facility failed to provide treatment as prescribed in Patient #1's POC. 2. Patients were not provided with BFRs as ordered in their POCs as follows: a. Patient #3 was a 44 year old male who had been dialyzing at the facility since 3/2/15. Seven treatment sheets from 5/25/15 - 6/10/15 were reviewed. These treatment sheets documented Patient #3 was dialyzing through a CVC with a 400 ml/minute BFR ordered. His prescribed BFR was not maintained for 5 of 7 treatments as indicated by the following average BFRs: 5/29/15 - 344 ml/min. average BFR 6/3/15 - 371 ml/min. average BFR 6/6/15 - 330 ml/min. average BFR 6/8/15 - 389 ml/min. average BFR 6/10/15 - 365 ml/min. average BFR There was no documentation explaining why the prescribed BFR was not attained for Patient #3. Additionally, there was no documentation that	V 463		

PRINTED: 07/02/2015
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 _____	06/26/2015

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 463	Continued From page 3 showed the cause of low BFR had been investigated. b. Patient #2 was an 82 year old male who had been dialyzing at the facility since 3/30/15. A treatment sheet, dated 5/25/15, showed the average BFR for Patient #2's treatment was 250 ml/min. All data in the Prescription Information area of his record indicated Patient #2 was dialyzing through his CVC, including an order for BFR to be 400 ml/min. There was no documentation explaining why the prescribed BFR was not attained for Patient #2. Additionally, there was no documentation showing that the cause of low BFR had been investigated. In an interview on 6/23/15 at 2:00 p.m., the FA confirmed the BFR data and the lack of documentation for Patients #2 and #3.	V 463		
V 516	The facility failed to provide treatment as prescribed in the POCs for Patients #2 and #3. 494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the facility failed to	V 516	V 516 The FA in-serviced IDT teammates 06/24/15 on policy #3-02-02: Medical Record Preparation and Charting Guidance. The FA in-serviced IDT teammates 7/7/2015 on policy 1-14-02: Patient Assessment and Plan of Care When Utilizing Falcon Dialysis and policy 1-03-07: New Patient Evaluation. Teammates were instructed on: 1. Assessments and Care Planning to include but not limited to timelines and accuracy. 2. Completing initial Assessments within 30 days or 13 treatments from admission. Continued on next page	

PRINTED: 07/02/2015
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 _____	06/26/2015

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 516	Continued From page 4 ensure a comprehensive initial assessment was completed within 30 days or 13 treatments of the initiation of dialysis for 1 of 1 patient (Patient #2) who had started dialysis within the last 90 days. Failure to complete an initial assessment in a timely manner had the potential to result in unmet patient needs. Findings include: Patient #2 was an 82 year old male who began dialyzing at the facility on 3/30/15. A review of his record showed an initial comprehensive assessment was completed, as indicated by IDT signatures, on 5/22/15. In an interview on 6/24/15 at 3:00 p.m., the FA confirmed the date for Patient #2's initial assessment and said the assessment was late. The facility failed to ensure a comprehensive initial assessment was completed in a timely manner for Patient #2.	V 516	3. The responsibilities of the IDT. Patient #2's Assessment and Plan of Care is complete and current at this time. The FA will monitor the timely completion of new patients admitted to the facility. Audits will review assessments and care plans through the use of "Falcon Reports" to insure that proper assessments and care plans are completed on time. These audits will be completed on a monthly basis x 3 months then quarterly thereafter. Audits will be reviewed by the Medical director during the monthly QAPI with an improvement plan developed if needed. The FA is responsible for compliance.	7/20/15
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 a POC was implemented by addressing volume status for 2 of 4 ICHD patients (Patients #2 and #3) whose records were reviewed. This failure resulted in the patients being put at risk of complications resulting from fluid overload.	V 543	V 543 The FA in-serviced clinical teammates 06/24/15 on DaVita education course: "Fluidwise Focus Patient Management". The FA in-serviced clinical teammates 7/7/15 on policy 3-02-03: Orders for Patient Care, policy 3-02-10: Physician Order Policy, and DaVita education courses: "Fluidwise Facility Performance Management", "Fluidwise Management" and "Fluidwise Clinical Pathway". During inservices, teammates were instructed on fluid management to include but not limited to: Continued on next page	

PRINTED: 07/02/2015
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 _____	06/26/2015

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 543	Continued From page 5 Findings include: 1. Patient #3 was a 44 year old male who had been dialyzing at the facility since 3/2/15. Twelve treatment sheets from 5/25/15 - 6/22/15 were reviewed. Pre-dialysis weights, volume removed (an automatic download from the machine to the treatment sheet), and post dialysis weights were compared to his prescribed EDW with the following results: Date / Expected Post wt. / Actual Post wt. 5/25/15 — 71.3 kg — 73.5 kg 6/03/15 — 72.0 kg — 73.9 kg 6/08/15 — 72.9 kg — 74.0 kg 6/19/15 — 72.7 kg — 73.7 kg Patient #3 failed to attain his EDW during 4 of 12 treatments reviewed. In an interview on 6/23/15 at 2:00 p.m., the FA confirmed the weight discrepancies for Patient #3. He said that neither pre-dialysis or post dialysis weights were routinely witnessed by staff and could have been inaccurately recorded by the patient. The facility failed to ensure volume status was managed for Patient #3. 2. Patient #2 was an 82 year old patient who began dialyzing at the facility on 3/30/15. Six treatment sheets from 5/25/15 - 6/10/15 were reviewed. Patient #2 had a prescribed EDW of 62.5 kg. One treatment sheet, dated 6/1/15, showed Patient #2 had a pre-dialysis weight of	V 543	1. the importance of following physician orders and communication when variation occurs. 2. The importance of insuring the patient is properly weighed pre and post dialysis to accurately achieve EDW. 3. How to properly set dialysis machine goals for the prescribed removal of fluid as outlined in the POC. Patient education is provided to all patients during the week beginning 7/12/15 by the teammates on the proper use of the patient scale to include but not limited to: 1. How to zero the scale before each use. 2. Waiting for the completion of the zeroing of the scale prior to stepping on the scale. 3. The importance of weighing in the same attire pre and post dialysis. 4. How to weigh using a wheelchair and obtaining the accurate weight of the wheelchair. 5. Requesting assistance of the teammates when in doubt of any of these issues. Patients #2 and #3 were immediately educated on the proper use of the patient scale as outlined above. Patients #2 and #3's EDW is scheduled for reassessment by the IDT team during next scheduled physician rounds. Orders will be updated as necessary. The FA will monitor weights through the use of the "Post Treatment tool" to insure the patients are obtaining their EDW per the POC. This audit will be conducted daily for all patients for 2 weeks, 30 % of patients for 2 weeks and 10% of patients quarterly thereafter. Audits will be reviewed by the Medical director during the monthly QAPI with an improvement plan developed if needed. The FA is responsible for compliance.	7/20/15

PRINTED: 07/02/2015
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 _____	06/26/2015

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 543	Continued From page 6 62.2 kg and a volume removed of 1 kg. His post dialysis weight was 65.9 kg. This reflected an actual weight gain of 4.7 kg over what was anticipated, and 3.4 kg above Patient #2's prescribed EDW. The patient presented for his next treatment on 6/3/15 weighing 68.5 kg, 6 kg above his prescribed EDW. In an interview on 6/23/15 at 2:00 p.m., the FA confirmed the data for Patient #2's 6/1/15 treatment. He said that neither pre-dialysis or post dialysis weights were routinely witnessed by staff and could have been inaccurately recorded by the patient. The facility failed to ensure volume status was managed for Patient #2.	V 543		
V 712	494.150(a) MD RESP-QAPI PROGRAM Medical director responsibilities include, but are not limited to, the following: (a) Quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on record review, policy review, QAPI documentation review, and staff interview, it was determined the facility failed to ensure the medical director's responsibility for the operation and oversight of the QAPI program was upheld. This failure placed the safety of all facility patients at risk due to inadequate AOR tracking. Findings include: A policy titled Adverse Occurrence Reporting Policy, dated 6/2013, stated "Any unexpected event that is inconsistent with the routine operation of a dialysis facility, routine provision of	V 712	V 712 An AOR for patient #2 was generated immediately on 6/23/15 and the physician was notified as well as the Medical Director. A Governing Body was convened on 6/29 2015 where the Medical Director defined "Treatment Error" as: Any aspect of the dialysis treatment that fails to follow the prescribed treatment as outlined in the plan of care and as ordered by the physician without physician approval. The FA in-serviced clinical teammates 06/24/15 on policy #3-02-02: Medical Record Preparation and Charting Guidance. The FA in-serviced clinical teammates 07/07/15 on policy 13-01-02: Adverse Occurrence Reporting Policy, policy 3-02-03: Orders For Patient Care, policy 3-02-10: Physician Order Policy, and DaVita education courses: "Adverse Occurrence Reporting", "Legal Aspects of Documentation", "Documentation Basic Training", "Documentation-Chair Side Snappy" and "SMART Documentation". Continued on next page	

PRINTED: 07/02/2015
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
	132603	A. BUILDING _____ B. WING _____	06/26/2015

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 712	Continued From page 7 acute dialysis or ancillary renal-related services may be an adverse occurrence." The policy included a list of 76 examples of reportable occurrences. One of the categories to be reported was "treatment error." There was no information to further clarify what might constitute a treatment error. Patient #2 was an 82 year old male who had been dialyzing at the facility since 3/30/15. His dialysis prescription included a treatment time of 4 hours, as well as the directive that no more than 2 L of fluid be removed during each hour of dialysis. During Patient #2's treatment on 6/8/15 the following was documented: Patient #2's UF goal, (the amount of fluid to be removed during his 4 hour treatment,) was calculated to be 4 kg and this value was entered into the dialysis machine pre-treatment. Treatment began at 11:12 a.m. At 12:50 p.m. it was discovered the UF pump had not been activated and only 0.7 kg of fluid had been removed during the first 1 hour and 47 minutes of treatment. At this time, the UF pump was activated and the UF goal remained at 4 kg. During the following 1 hour and 25 minutes of treatment 2.9 kg of fluid was removed from Patient #2. At 2:24 p.m. it was documented that Patient #2 "went out" indicating he lost consciousness. Vital signs showed he was bradycardic with a heart rate of 50 beats per minute. The UF goal was decreased, and 300 ml of normal saline was administered. While AORs were tracked by the facility's QAPI	V 712	Teammates were instructed on: 1. what constitutes an AOR to include but not limited to treatment error. 2. How to write an AOR. 3. Reporting responsibilities of an AOR. 4. All aspects of proper documentation to include rationale for variations to treatment prescription and the notification of the physician when such variations occur. 5. The importance of following physician orders and communication when unable to do so. The FA will monitor treatments through the use of the "Post Treatment tool" to insure the patients are receiving their treatment per the POC and that any variation is approved by the physician. An AOR will be generated for any variation not approved by the physician. This audit will be conducted daily for all patients for 2 weeks, 30 % of patients for 2 weeks and 10% of patients quarterly thereafter. These audits and related AORs will be reviewed by the Medical director during the monthly QAPI with an improvement plan developed if needed. The FA and Medical Director are responsible for compliance.	7/20/15

PRINTED: 07/02/2015
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 _____	06/26/2015

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 712	Continued From page 8 process, a review of current data collected for presentation at the facility's monthly QAPI meeting showed an AOR had not been done for this adverse occurrence. In an interview on 6/23/15 at 2:00 p.m., the FA confirmed Patient #2's 6/8/15 treatment details and said an AOR should have been generated but was not. Data was not accurately collected for the QAPI committee to review and assess.	V 712		