IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7012 3050 0001 2125 5815

April 8, 2016

Jordana Ratel, Administrator
Post Falls Dialysis
1300 East Mullan, Suite 1200
Post Falls, ID 83854-6052

RE: Post Falls Dialysis, Provider #132508

Dear Ms. Ratel:

Based on the survey completed at Post Falls Dialysis, on April 1, 2016, by our staff, we have determined Post Falls Dialysis is out of compliance with the Medicare ESRD Conditions for Coverage of **CFC-PATIENT PLAN OF CARE (42 CFR 494.90), CFC-QAP1 (42 CFR 494.110) and CFC-REPONSIBILITIES OF THE MEDICAL DIRECTOR (42 CFR 494.150)**. 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 these conditions to be unmet, substantially limit the capacity of Post Falls Dialysis, 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 May 16, 2016. 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 April 22, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 21, 2016**.

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.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

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

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Gary Keopanya, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132508	A. BUILDING _____ B. WING _____	04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POST FALLS DIALYSIS	1300 EAST MULLAN, SUITE 1200 POST FALLS, ID 83854

(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 The following deficiencies were cited during the recertification survey of your facility. The surveyors conducting the survey were: Trish O'Hara RN, HFS, Team Leader Laura Thhompson RN, HFS Acronyms used in this report: AMA - Against Medical Advice CVC - Central Venous Catheter EDW - Estimated Dry Weight ICHD - Incenter Hemodialysis kg - kilogram Kt/V - Measure of dialysis adequacy ml - milliliter POC - Plan Of Care QAI - Quality Assurance and Improvement QAPI - Quality Assurance Performance Improvement QSR - Quality Status Report	V 000	RECEIVED APR 20 2016 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; 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 each patient's right to receive care as outlined in their POCs was upheld for 4 of 4 ICHD patients (Patients #1 - #4) whose treatment records were reviewed. This resulted in patients'	V 463		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordana Kate, RN | TITLE: RN | (X6) DATE: 4/18/16

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 463	Continued From page 1 not receiving treatments as ordered with regard to time on the machine, which placed them at risk for decreased adequacy. Additionally, vital signs were not monitored during treatment placing patients at risk for complications. Findings include: 1. A facility policy "Patient Monitoring During Patient Treatment," revised 8/20/14, stated "Vital signs will be monitored at the initiation of dialysis and every 30 minutes, or more frequently, as needed. Observe for changes in the patient's respirations, heart rate and blood pressure. Verify and react to unusual findings such as atypical blood pressure readings." This policy was not followed. Vital sign monitoring was not done every 30 minutes as follows: a. Patient #1 was a 61 year old female. Eleven treatment records, from 2/29/16 to 3/29/16, were reviewed and 4 of 13 treatments did not include documentation of vital signs every 30 minutes. - On 2/29/16, no vital signs were recorded for 48 minutes, from 5:47 AM to 6:35 AM. - On 3/7/16, no vital signs were recorded for 59 minutes, from 6:35 AM to 7:34 AM. - On 3/11/16, no vital signs were recorded for 1 hour and 8 minutes, from 7:01 AM to 8:09 AM. - On 3/14/16, no vital signs were recorded for 1 hour and 6 minutes, from 7:33 AM to 8:39 AM. b. Patient #2 was a 47 year old male. Thirteen treatment records, from 2/29/16 to 3/28/16, were	V 463		

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V 463	Continued From page 2 reviewed and 5 of 13 treatments did not include documentation of vital signs every 30 minutes. - On 3/4/16, no vital signs were recorded for 1 hour and 35 minutes, from 12:32 PM to 2:07 PM. - On 3/7/16, no vital signs were recorded for 57 minutes, from 2:33 PM to the end of his dialysis treatment at 3:30 PM. - On 3/9/16, no vital signs were recorded for 1 hour and 3 minutes, from 2:03 PM to 3:06 PM. - On 3/21/16, no vital signs were recorded for 54 minutes, from 2:39 PM to the end of his dialysis treatment at 3:32 PM. - On 3/28/16, no vital signs were recorded for 1 hour and 17 minutes, from 12:48 PM to 2:05 PM. c. Patient #3 was a 67 year old male. Thirteen treatment records, from 2/29/16 to 3/28/16, were reviewed and 8 of 13 treatments did not include documentation of vital signs every 30 minutes. - On 3/2/16, no vital signs were recorded for 51 minutes, from 9:00 AM to 9:51 AM. - On 3/4/16, no vital signs were recorded for 2 hours and 22 minutes, from 7:32 AM to the end of his treatment at 9:54 AM. - On 3/7/16, no vital signs were recorded for 1 hour and 4 minutes, from 7:36 AM to 8:40 AM. - On 3/9/16, no vital signs were recorded for 1 hour and 27 minutes, from 7:38 AM to 9:05 AM. - On 3/11/16, no vital signs were recorded for 1	V 463		

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V 463	Continued From page 3 hour and 35 minutes, from 8:09 AM to 9:44 AM. - On 3/14/16, no vital signs were recorded for 57 minutes, from 6:33 AM to 7:30 AM and for 1 hour and 6 minutes, from 8:36 AM to 9:42 AM. - On 3/21/16, no vital signs were recorded for 1 hour and 14 minutes, from 8:05 AM to 9:19 AM. - On 3/28/16, no vital signs were recorded for 59 minutes, from 8:05 AM to 9:04 AM. d. Patient #4 was a 72 year old female. Twelve treatment records, from 3/1/16 to 3/26/16, were reviewed and 5 of 12 treatments did not include documentation of vital signs every 30 minutes. - On 3/1/16, no vital signs were recorded for 1 hour and 9 minutes, from 9:35 AM to 10:44 AM. - On 3/8/16, no vital signs were recorded for 51 minutes, from 10:09 AM to 11:00 AM. - On 3/12/16, no vital signs were recorded for 58 minutes, from 9:06 AM to 10:04 AM. - On 3/17/16, no vital signs were recorded for 1 hour and 7 minutes, from 10:35 AM to the end of her dialysis treatment at 11:42 AM. - On 3/26/16, no vital signs were recorded for 1 hour, from 8:04 AM to 9:04 AM. During an interview beginning at 3:35 PM on 3/30/16, the Charge Nurse reviewed the treatment records and confirmed vital signs were not recorded on treatment records according to facility policy. She stated monitoring of vital signs was done every 30 minutes by the machine	V 463		

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V 463	Continued From page 4 automatically, if set to do so by a staff member. The Charge Nurse stated if the information was not manually transferred, after 15 minutes, by a staff member the information would not be documented on the treatment record. The facility failed to ensure vital signs were monitored according to policy. 2. Treatment times were shortened from the prescribed time indicated on POCs without explanation of the missed time being documented in the patients' records. A facility policy "Early Termination or Arriving Late for Treatment," revised 7/4/12, stated "If a patient insists on terminating treatment early and this has not been previously approved by the patient's physician, the patient must take full responsibility for consequences of the missed or shortened treatment. The RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. The RN is responsible to notifiy the physician, and document on the 'AMA', or Against Medical Advice form." The policy further stated the AMA forms must be signed with each early termination event and filed in the patient's record. This policy was not followed. During a phone interview at 9:00 AM on 3/31/16, the Clinical Manager stated AMA forms must be signed every time a treatment was ended prior to the prescribed time, unless the patient was experiencing symptoms. She stated the physician should be notified by the RN or Technician of a shortened treatment. The Clinical Manager further stated the reason for the	V 463		

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V 463	Continued From page 5 shortened treatment time and discussion with the physician must be documented in the patient's record. a. Patient #1 was a 61 year old female. Thirteen treatment records, from 2/29/16 to 3/29/16, were reviewed. Her POC documented treatment time was for 3 hours and 15 minutes. Patient #1 missed 2 treatments on 3/4/16 and 3/28/16. Additionally, 10 of 11 treatment times were shortened as follows: - 2/29/16: 6 minutes - 3/2/16: 4 minutes - 3/4/16: 195 minutes (missed treatment) - 3/7/16: 7 minutes - 3/9/16: 5 minutes - 3/11/16: 8 minutes - 3/14/16: 6 minutes - 3/18/16: 5 minutes - 3/21/16: 90 minutes - 3/23/16: 2 minutes - 3/25/16: 19 minutes - 3/28/16: 195 minutes (missed treatment) Patient #1 missed a total of 5 hours and 2 minutes of her prescribed treatment time during. There was no documentation in her treatment	V 463		

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V 463	Continued From page 6 records why her time was shortened or that her physician was notified. Additionally, there were no AMA forms signed by Patient #1 for the days her treatments were shortened or missed. During the reviewed period, Patient #1's Kt/V decreased from 1.32, on 2/22/16, to 1.16 on 3/23/16. There was no documentation that Patient #1's decreased Kt/V values were addressed. During an interview at 3:20 PM on 3/30/16, the Charge Nurse reviewed Patient #1's record and confirmed the prescribed treatments were shortened as documented above. She stated Patient #1 often complained about needing to use the bathroom towards the end of her treatment due to her ostomy. The Charge Nurse confirmed this was not documented in her record. She further confirmed AMA forms were not in Patient #1's record for the shortened treatments. b. Patient #2 was a 47 year old male. Thirteen treatment records, from 2/29/16 to 3/29/16, were reviewed. His POC documented treatment time was for 2 hours and 45 minutes. Patient #2's treatments were shortened 2 of 13 times as follows: - 3/2/16: 115 minutes - 3/16/16: 49 minutes Patient #2 missed a total of 2 hours and 44 minutes of his prescribed treatment time. There was no documentation in his treatment records why his time was shortened or that his physician was notified. Additionally, there were no AMA forms signed by Patient #2 for the shortened	V 463		

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V 463	Continued From page 7 treatments. During an interview at 4:05 PM on 3/30/16, the Charge Nurse reviewed Patient #2's record and confirmed his treatments were shortened on the 2 days documented above. She confirmed his record did not include AMA forms signed by Patient #2 for the shortened treatment times. c. Patient #3 was a 67 year old male. Thirteen treatment records, from 2/29/16 to 3/28/16, were reviewed. His POC documented treatment time was for 3 hours and 30 minutes from 2/29/16 to 3/23/16. From 3/23/16 to 3/28/16 Patient #3's treatment time increased to 3 hours and 45 minutes. Patient #3's treatment times were shortened as follows: - 3/21/16: 35 minutes - 3/23/16: 10 minutes - 3/25/16: 2 minutes Patient #3 missed a total of 47 minutes of his prescribed treatment time. There was no documentation in Patient #3's record that his physician was notified or why his treatments ended earlier than prescribed. Additionally, there were no AMA forms signed by Patient #3 for the shortened treatments. During the reviewed period, Patient #3's adequacy was consistently below the minimum standard of 1.2, with values of 1.09 on 2/22/16, and 1.13 on 3/23/16. Patient #3's treatment time was increased to 3.75 hours on 3/23/16. However, he did not receive the newly prescribed treatment time on 3/23 and 3/25/16. There was	V 463		

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V 463	Continued From page 8 no documentation why he did not receive his full treatment time on those days. During an interview at 3:50 PM on 3/30/16, the Charge Nurse reviewed Patient #3's record and confirmed his treatments were shortened on the 3 days documented above. She confirmed his record did not include AMA forms signed by Patient #3 for the shortened treatment times. d. Patient #4 was a 72 year old female. Thirteen treatment records, from 2/29/16 to 3/28/16, were reviewed. Her POC documented treatment time was 4 hours. Patient #4's treatment times were shortened as follows: - 3/15/16: 7 minutes - 3/19/16: 7 minutes Patient #4 missed a total of 14 minutes of her prescribed treatment time. There was no documentation in Patient #4's record that her physician was notified or why her treatments ended earlier than prescribed. Additionally, there were no AMA forms signed by Patient #4 for the shortened treatments. During an interview at 3:35 PM on 3/30/16, the Charge Nurse reviewed Patient #4's record and confirmed her treatments were shortened on the 2 days documented above. She confirmed her record did not include AMA forms signed by Patient #4 for the shortened treatment times. The facility failed to ensure treatment times were completed as ordered, and the policy was followed for shortened treatments.	V 463		

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V 540	Continued From page 9	V 540		
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on staff interview, review of clinical records, and review of policy and procedure, it was determined the facility failed to recognize and meet individual patient needs. The cumulative effects of these failures resulted in patients' individual needs not being addressed and patients not receiving care as ordered by their physicians. Findings include: 1. Refer to V463 as it relates to the facility's failure to uphold the patients' rights to receive care as prescribed in their plans of care. 2. Refer to V543 as it relates to the facility's failure to ensure patients' POCs were implemented by addressing volume status. The cumulative effect of these systemic failures impeded the ability of the facility to provide services of sufficient scope and quality.	V 540		
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 #1 and	V 543		

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V 543	Continued From page 10	V 543		

#4) whose records were reviewed. This failure resulted in the patients being put at risk of complications resulting from fluid overload or dehydration. Findings include:

The Medical Director was interviewed on 4/4/16, at 12:05 PM. When she was asked about patients' EDWs she stated those were established and set by herself. The Medical Director stated RNs were allowed to make small changes, up or down, to the EDW by 0.5 kg. She stated any adjustment to EDW by more than 0.5 kg must be discussed with her. Additionally, the Medical Director stated if a patient were consistently above their EDW post dialysis she expected the RN to inform her.

1. Patient #1 was a 61 year old female who was a dialysis patient at the facility since 11/03/07. Eleven treatments, from 2/29/16 to 3/29/16, were reviewed. Pre-dialysis weights, volume of fluid removed (an automatic download from the machine to the treatment sheet), and post dialysis weights were compared to her prescribed EDW.

Patient #1 missed her treatment on 3/4/16, and received her next treatment on 3/7/16. Her pre-dialysis weight was 75.6 kg. During treatment 674 ml of fluid was removed and 400 ml was given. Patient #1's post dialysis weight was 75.9 kg, 2.9 kg over her EDW.

Patient #1's pre-dialysis weight on 3/9/16, was 75 kg. During treatment 840 ml of fluid was removed and 800 ml of fluid was given. Patient #1's post dialysis weight was 74.6 kg, 1.6 kg over her EDW.

Patient #1's pre-dialysis weight on 3/11/16, was

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V 543	Continued From page 11	V 543		

74.8 kg. During treatment 908 ml of fluid was removed and 600 ml of fluid was given. Patient #1's post dialysis weight was 75 kg, 2 kg over her EDW.

Patient #1's EDW was increased by 2 kg from 73 kg to 75 kg on 3/14/16. Her pre-dialysis weight that day was 74.7 kg. During treatment 882 ml of fluid was removed and 200 ml of fluid was given. Patient #1's post dialysis weight was 74.5 kg, 0.5 kg under her new EDW.

Patient #1's pre-dialysis weight on 3/16/16, was 73.3 kg. During treatment 931 ml of fluid was removed and 1.4 liters of fluid was given. Patient #1's post dialysis weight was 74.3 kg, 0.7 kg under her EDW.

Patient #1's pre-dialysis weight on 3/18/16 was 73.6 kg, 1.4 kg under her EDW. During treatment 936 ml of fluid was removed and 1.2 liters of fluid was given. Patient #1's post dialysis weight was 74.5 kg, 0.5 kg under her EDW.

Patient #1's pre-dialysis weight was 72.9 kg at her next treatment, on 3/21/16, 2.1 kg under her EDW. During treatment 540 ml of fluid was removed and 900 ml of fluid was given. Patient #1's post dialysis weight was 75.3 kg.

Patient #1's weight was under her EDW of 75 kg, pre-dialysis, for 5 out of 6 treatments after her EDW was increased. Additionally, her post dialysis weight was under her EDW for 3 of 6 treatments.

During an interview at 3:15 PM on 3/30/16, the Charge Nurse reviewed Patient #1's record and confirmed she was under her EDW. She stated

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	132508	A. BUILDING _____ B. WING _____	04/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POST FALLS DIALYSIS	1300 EAST MULLAN, SUITE 1200 POST FALLS, ID 83854

(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 12 due to Patient #1's ostomy and gastrointestinal problems her weight fluctuated. When asked who established the EDW for patients she stated she would decide what the EDW should be for patients. The facility failed to ensure Patient #1's volume status was managed appropriately. 2. Patient #4 was a 72 year old female who was a dialysis patient at the facility since 2/23/16. Twelve treatment records, from 3/1/16 to 3/26/16, were reviewed. Pre-dialysis weights, volume of fluid removed (an automatic download from the machine to the treatment sheet), and post dialysis weights were compared to her prescribed EDW. Patient #4's EDW was 113 kg. Post dialysis weights were consistently above her EDW by 1 to 3 kg for 9 out of 11 of her treatments. Examples include: - 116 kg on 3/1/16 - 116.1 kg on 3/3/16 - 115.2 kg on 3/5/16 - 116.1 kg on 3/8/16 - 114.9 kg on 3/10/16 - 114.3 kg on 3/12/16 - 114.5 kg on 3/15/16 - 114.4 kg on 3/19/16 - 115 kg on 3/22/16	V 543		

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V 543	Continued From page 13 - 114.3 kg on 3/24/16 The RN documented in the treatment record, dated 3/12/16, Patient #4's EDW would be increased. However, her EDW was not increased for subsequent treatments. Additionally, there was no documentation in the record Patient #4's physician was notified of her post dialysis weights. During an interview at 3:35 PM on 3/30/16, the Charge Nurse reviewed Patient #4's record and confirmed she was above her EDW post dialysis for most of her treatments. She stated patients should be within 0.5 kg of their EDW post dialysis. The Charge Nurse confirmed Patient #4's EDW was not increased per her documentation on 3/12/16. The facility failed to ensure Patient #4's volume status was managed appropriately.	V 543		
V 625	494.110 CFC-QAPI This CONDITION is not met as evidenced by: Based on staff interview and review of QAPI meeting minutes, it was determined the facility failed to ensure an effective QAPI program was maintained that collected data, and recognized and corrected problems affecting patients' health. This failure had the potential to decrease the quality of treatment received by patients. Findings include: 1. Refer to V626 as it relates to the lack of data collection for relevant patient quality indicators.	V 625		

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V 625	Continued From page 14 2. Refer to V638 as it relates to the lack of action plans, in response to poor patient outcomes, by the committee.	V 625		
V 626	494.110 QAPI-COVERS SCOPE SERV/EFFECTIVE/IDT INVOL The dialysis facility must develop, implement, maintain, and evaluate an effective, data-driven, quality assessment and performance improvement program with participation by the professional members of the interdisciplinary team. The program must reflect the complexity of the dialysis facility's organization and services (including those services provided under arrangement), and must focus on indicators related to improved health outcomes and the prevention and reduction of medical errors. The dialysis facility must maintain and demonstrate evidence of its quality improvement and performance improvement program for review by CMS. This STANDARD is not met as evidenced by: Based on staff interview and review of QAI documents, it was determined the facility failed to ensure the QAI program monitored and analyzed patient data related to shortened treatment times, and transplant referrals. This limited the facility's ability to identify and correct areas of patient care in need of improvement for 4 of 4 patients (Patients #1 - #4). Findings include: 1. Hemodialysis QSR reports for 11/2015, 1/2016, and 2/2016 were reviewed. These reports showed the QAI committee did not track patient treatments that were shorter than the time	V 626		

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V 626	Continued From page 15 prescribed. A policy titled Early Termination or Arriving Late for Treatment, revised 7/4/12, stated AMA forms were "Signed with each early termination event and filed in the patient's medical record." The policy further stated AMA forms were "Tracked, trended and reported to the QAI committee monthly." Patient #1 had 2 missed treatments and 10 shortened treatments from 2/29/16 - 3/28/16 with no AMAs documenting the events. Patient #2 had 2 shortened treatments from 3/2/16 - 3/16/16, with no AMAs documenting the events. Patient #3 had 3 shortened treatments from 3/21/16 - 3/24/16, with no AMAs documenting the events. Patient #4 had 2 shortened treatments from 3/15/16 - 3/19/16, with no AMAs documenting the events. In an interview on 4/4/16 at 11:30 a.m., the nurse manager said the total number of missed treatments were tracked and trended for QAI purposes, but shortened treatments were not. She said the facility had the capability to augment the corporate template for the QSR by collecting additional data not required by the template, but this was not being done at this time. 2. The hemodialysis QSR reports did not include data relative to patient referrals to kidney transplant centers for potential work up.	V 626		

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V 626	Continued From page 16 In an interview on 4/4/16 at 12:00 p.m., the Medical Director confirmed patient education, concerning transplant as a treatment option, was tracked by the QAI committee but actual patient referrals were not. A policy titled Patient Education, dated 6/19/13, stated "The Conditions and this policy require that all patients be educated on an ongoing basis as needed to achieve the goals in their Plan of Care." The policy included 10 areas of education, including transplant status. Under the transplant status area it was stated "The patient record must show evidence that the patient was informed about transplantation as an option, living and deceased kidney donation, area transplant centers and each transplant facility's selection criteria." The facility failed to ensure all patient outcomes were included in the QAI program.	V 626		
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI committee meeting minutes, it was determined the facility failed to ensure remedial actions were taken to improve outcomes for ICHD patients. This failure had the potential to impact all patients through less than optimal outcomes. Findings	V 638		

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V 638	Continued From page 17 include: 1. QSR data was reviewed for 11/2015, 1/2016, and 2/2016 to identify patients who had received Hepatitis B vaccinations. The corporate goal was set at 100% of eligible patients receiving the vaccine. November, 2015 data showed 45.5% of eligible patients had received the Hepatitis B vaccine. January, 2016 data showed 57.9% of eligible patients had received the vaccine. February, 2016 data showed 47.4% of eligible patients had received the vaccine. There was no evidence an action plan had been initiated in response to the low number of eligible patients receiving the vaccine. 2. QSR data was reviewed for 11/2015, 1/2016, and 2/2016 to identify patients who did not attain minimum standard dialysis adequacy. The minimum facility goal for adequacy expected 97.6% of patients to have a 3 month average Kt/V value of >= 1.2. November, 2015 data showed 97.1% of facility patients had attained the goal. January, 2016 data showed 88.6% of facility patients had attained the goal. February, 2016 data showed 85.7% of patients had attained the goal. There was no evidence an action plan had been initiated in response to the decreasing number of patients attaining the expected adequacy goal. 3. QSR data was reviewed for 11/2015, 1/2016, and 2/2016 to identify patients who had a central venous catheter in place for longer than 90 days. The minimum facility goal expected 92% of patients would not have a CVC. November, 2015 data showed 85.7% of patients did not have a CVC, January, 2016 data showed 88.6% of patients did not have a CVC, and February, 2016	V 638		

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V 638	Continued From page 18 data showed 86.5% of patients did not have a CVC in place. There was no evidence an action plan had been initiated in response to not attaining the minimum goal of 92%. In an interview on 4/7/16 at 10:00 a.m., the nurse manager said she was new to the facility and was in the process of identifying priority areas for improvement. The facility failed to ensure effective QAPI action plans were initiated to ensure goals were attained.	V 638		
V 710	494.150 CFC-RESPONSIBILITIES OF THE MEDICAL DIRECTOR This CONDITION is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure the Medical Director provided oversight needed to ensure the delivery of quality patient care and to ensure the operation of an effective QAPI program. This failure created the potential for negative patient outcome for all patients dialyzing at the facility. Findings include: 1. Refer to V625:Condition for Coverage QAPI, and associated standard level deficiencies as they relate to the Medical Director's failure to ensure the operation of an effective QAPI program. 2. Refer to V540:Condition for Coverage Patient Plan of Care and associated standard level deficiencies as they relate to the Medical Director's failure to ensure patients' dialysis treatments were delivered as prescribed.	V 710		

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RECEIVED
APR 20 2016
FACILITY STANDARDS

Fresenius Medical Care Post Falls Dialysis

CMS Provider 132508

Plan of Correction:

V 463 494.70(a)(12) PR-Receive Services outlined in POC

The Clinical Manager held a meeting on 4/13/16 and 4/14/16 with DPC staff to review and re-educate on the following policies: FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy, FMS-CS-IC-I-110-133A, Monitoring During Patient Treatment Policy. Emphasis was placed on monitoring VS at the initiation and every 30 minutes, or more frequently, as needed. The staff will observe for changes in patient's respirations, heart rate and blood pressure. Also discussed when to react to unusual findings such as atypical blood pressure readings.

- All patients will have VS documented at least every 30 minutes or more frequently as needed/directed by nursing staff.
- Starting 4/11/2016 Clinical Manager or designee for a period of two weeks will daily monitor 50% of patient treatment sheets for variances >30min checks. Adherence to the policy will result in the frequency reduced to 25% 3X weekly for two additional weeks and then 25% once a week for two weeks using daily audit tool. On-going monitoring will continue. Once compliance sustained monitoring will be done through the medical record audit per QAI calendar.
- Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.
- Audit results will be reviewed and presented to the QAI team beginning April 18, 2016. The QAI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight.
- The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting until the sustained resolution of all identified issues is determined.
- The governing body is responsible to review and analyze all data including monitoring results for issues and trends. Based on the audit results the governing body will make determination as to the frequency of the audits moving forward.

The Clinical Manager held a meeting on 4/13/16 and 4/14/16 with DPC staff to review and re-educate on the following policies: FMS-CS-IC-I-110-144A Early Termination or Arriving Late for Treatment and FMS-CS-IC-I-103-010A Patient Non-Adherence to Schedule. Emphasis is placed on re-educating if a patient insists on terminating treatment early and this has not been previously approved by the patient's physician, the patient must take full responsibility for consequences of the missed or shortened treatment. The RN who evaluates the patient must document the rationale for early termination and reinforce the consequences of not receiving the entire prescribed treatment. The RN is responsible to notify the physician, and document on the AMA, signed by the patient, and placed in the medical record.

Effective immediately:

- Patients who are missing treatment will be offered a make-up treatment for later in the day or for the following day. Any patient that refuses to make up treatment time will have reeducation on the importance of attendance to every treatment and given education materials at their next scheduled appointment. The physician will be notified of missed treatments and whether the patient is rescheduled or refusing to reschedule.
- Patients who are shortening their treatments will be continuously educated on the importance of running their entire treatment time and will be documented in chairside by person providing the education. The charge nurse/team leader (RN) will follow up on educating the patient by providing education material and provide further documentation in eCC. All patients will sign AMA form which will be placed in their charts under 'Problem List' tab and a copy will be given to the clinical manager. In addition to the AMA form being signed by patient and staff, the reason for ending treatment early will be written on the AMA.
- Missed or Shortened Treatment Report (MOST) will be ran monthly by clinical manager or designee and reviewed with the physician or her delegate. The charge nurse/team leader (RN) will review the report with the patients and have them sign and will be placed in their chart under 'treatment record'.
- The AMA forms and MOST report will be reviewed and presented to the QAI committee starting April 18, 2016.
- The QAI committee will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight.
- The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting until the sustained resolution of all identified issues is determined.
- The governing body is responsible to review and analyze all data including monitoring results for issues and trends. Based on the audit results the governing body will make determination as to the frequency of the audits moving forward.
- Inservice sheets are available for review.
- The deficiency was corrected on 4/18/2016

V540 494.90 CFC-PATIENT PLAN OF CARE

The Governing Body acknowledges its responsibility to ensure Fresenius Medical Care Dialysis Services Post Falls Dialysis meets the needs of the patients by ensuring patients' individual needs be addressed and patients receive care as ordered by their physician.

The Governing Body, on 4/12/2016 reviewed the SOD and developed the following

Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The following action steps were implemented:

The Governing Body, at its meeting on 4/12/2016, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Effective immediately:

The Clinical Manager (CM) will analyze and trend all data and audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.

- The Governing Body will review root cause analysis trending to identify and take action to reduce future events that could cause harm to patients in the facility.
- A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.
- The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting until the sustained resolution of all identified issues is determined.
- Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.
    - The responses provided for V543 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance

V543 494.90 (a)(1) POC-MANAGE VOLUME STATUS

The Clinical Manager held a meeting on 4/13/16 and 4/14/16 with DPC staff to review and re-educate on the following policies: FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy, FMS-CS-IC-I-110-133A, Monitoring DuringPatient Treatment Policy and FMS-CS-IC-I-105-001C Initiation of Treatment Using an Arteriovenous Graft or Fistula and Optiflux Single Use Ebeam Dialyzer. Emphasis was placed on ensuring a plan of care was implemented by addressing volume status to reduce risk for fluid overload or dehydration.

Effective immediately:

- No changes to dry weights will take place without physician order.
- All patients will be referred to the charge nurse/team leader (RN) for any post treatment weight with a variance from the estimated dry weight of 0.5kg

Effective 4/11/2016:

- Clinical Manager or designee for a period of two weeks will weekly monitor 50% of patient treatment sheets for variances > 0.5 kg's. Adherence to the policy will result in the frequency reduced to 25% 2X weekly for two additional weeks and then 10% once a week for two weeks. Once compliance sustained monitoring will be done through the medical record audit per QAI calendar.
- Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.
- Audit results will be reviewed and presented to the QAI team beginning April 18, 2016. The QAI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight.
- The Director of Operations is responsible to ensure all documentation required to ensure the solution of the deficiencies is provided to the QAI committee on a monthly basis.
- The governing body is responsible to provide oversite to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.
- Inservice sheets are available for review.
- The deficiency was corrected on 4/18/2016

V 625 494.110 CFC-QAPI

The Governing Body acknowledges its responsibility to ensure Fresenius Medical Care Dialysis Services Post Falls Dialysis meets the needs of the patients by ensuring patients' individual needs be addressed and patients receive care as ordered by their physician.

The Governing Body, on 4/12/2016 reviewed the SOD and developed the following

Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The following action steps were implemented:

The Governing Body, at its meeting on 4/12/2016, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Effective immediately:

The Clinical Manager (CM) will analyze and trend all data and audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.

- The Governing Body will review root cause analysis trending to identify and take action to reduce future events that could cause harm to patients in the facility.

- A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.
- The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting until the sustained resolution of all identified issues is determined.
- Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.
    - The responses provided for V626 and 638 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance
- The deficiency was corrected on 4/18/2016

V 626 494.110 QAPI-Covers Scope Serv/Effective/IDT INVOL

The Clinical Manager held a meeting on 4/13/16 and 4/14/16 with DPC staff to review and re-educate on the following policies: FMS-CS-IC-I-110-144A Early Termination or Arriving Late for Treatment and FMS-CS-IC-I-103-010A Patient Non-Adherence to Schedule.

On 4/18/2016 the clinical manager reviewed the following policy, 4/18/FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care to the entire interdisciplinary team with special emphasis that patient record must show evidence that the patient was informed about transplantation as an option, living and deceased kidney donation, area transplant centers and each transplant facility's selection criteria. Also reeducated about trending tracking and analyzing shortened or missed treatments which also must be tracked, trended and analyzed.

Effective 4/11/2016:

- Patients who are missing treatment will be offered a make-up treatment for later in the day or for the following day. Any patient that refuses to make up treatment time will have reeducation on the importance of attendance to every treatment and given education materials at their next scheduled appointment. The physician will be notified of missed treatments and whether the patient is rescheduled or refusing to reschedule.
- Patients who are shortening their treatments will be continuously educated on the importance of running their entire treatment time and will be documented in chairside by person providing the education. The charge nurse/team leader (RN) will follow up on educating the patient by providing education material and provide further documentation in eCC. All patients will sign AMA form which will be placed in their charts under 'Problem List' tab and a copy will be given to the clinical manager. In addition to the AMA form being signed by patient and staff, the reason for coming off early will be written in on the bottom.

- Missed or Shortened Treatment Report (MOST) will be ran monthly by clinical manager or her designee and reviewed with the physician or her delegate. The charge nurse/team leader (RN) will review the report with the patients and have them sign and will be placed in their chart under 'treatment record'.
- The AMA forms and MOST report will be reviewed and presented to the QAI committee starting April 18, 2016. The QAI committee will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The Clinical Manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight. Implement action plans and indicated.
- The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The Director of Operations is responsible to ensure all documentation required to ensure the solution of the deficiencies is provided to the QAI committee on a monthly basis.
- The governing body is responsible to provide oversite to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The clinical manager reviewed the following policy and procedure with social worker on 4/14/16: FMS-CS-IC-I-101-044A Transplant Responsibilities

Effective immediately:

- All patients will be tracked by social worker and clinical manager.
- Transplant referral's will be copied and placed in patient's chart. The status will then be uploaded to a word document that will be audited by the clinic manager monthly.
- Any patients that have chosen not to go through the referral process will be consulted every 6 months and provided education materials. All education or refusal of education will be documented clearly in eCC and on the tracking word document.
- The transplant tracking document will be reviewed and presented to the QAI team beginning April 18, 2016. The QAI meeting will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained. The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight.
- The clinical manager will contact transplant team from Sacred Heart and Virginia Mason and request list of patient status regarding transplant by 5/15/2016. Also will invite to join the QAI meeting quarterly starting in May's QAI to review the transplant list and review active patients and patients on hold.
- The clinical Manager or designee will have updated transplant binder validating 100% patients have been educated on transplantation by 5/15/2016.
- CM will present transplant tracking form and bring it to QAI starting April 18th, 2016.
- Once 100% of patients have been informed about transplantation ongoing compliance will be tracked, trended, and analyzed each month in QAI by Clinical Manager by 5/15/2016.
- The Clinical Manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight. Action Plans will be implemented as indicated

- The Director of Operations is responsible to ensure all documentation required to ensure the solution of the deficiencies is provided to the QAI committee on a monthly basis.
- The governing body is responsible to provide oversite to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.
- Inservice sheets are available for review.
- The deficiency was corrected on 4/18/2016

V638 494.110 (b) QAPI-MONITOR/ACT/TRACK/SUSTAIN/IMPROVE

The Clinical Manager held a meeting on 4/13/16 and 4/14/16 with DPC staff to review and re-educate on the Hepatitis Summary Report, FMS-CS-IC-I-105-022C3 On-Line Clearance Testing – Adequacy Monitoring Program (AMP), and Catheter Reduction.

CM will use Hepatitis Summary report and QSR to update and order Hepatitis vaccines for susceptible and non-responders by 5/15/2016.

- Effective 4/18/2016, Clinical manager will bring both Hepatitis Summary Report and QSR reports to QAI and QAI committee will trend track and analyze data and implement action plans as indicated.
- All patients that are susceptible/not vaccinated will be enrolled in the Hep B series by 5/15/2016.
- Clinical Manager or designee will enter all non-responder patients into ecube by 5/15/2016
- Clinical Manager or designee will run the Hepatitis Summary report monthly and continually update as required.

Clinical Manager actions for adequacy below:

- All patients will be monitored every treatment for OLC-Amp light to be 'green'; any patients that are running in the 'yellow' will have documentation about interventions, possibilities for 'yellow' light in place. If unable to meet clearance for the treatment, RN will be notified by PCT and will begin to investigate monthly kt/v.
- All patients with a kt/v less than 1.4 will be redrawn. The charge nurse will verify that patient has been running their entire treatment prior to consulting physician for possible treatment order changes.
- Clinical Manager will run monthly lab report to track patient's with kt/v's < 1.2 weekly and make adjustments per physician order as indicated.

Clinical Manager actions for catheter reduction below:

- CM will bring catheter reduction workbook to QAI committee each month beginning 4/18/2016, and team will analyze, trend, and track data. Action plans will be initiated as indicated
- Catheter reduction workbook will be updated by 5/15/2016. CM will utilize the workbook to track catheters.
- Catheter champion, CM or designee, will monitor weekly and schedule patient surgical consult and mapping within 2 weeks of admission.
- All current catheters will be reviewed and appointments will be made by 5/15/2016.

- The QAI committee will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
- The clinical manager will be responsible to review, analyze, and trend results and present to QAI committee for review and oversight. Action plans will be implemented as indicated.
- The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting until the sustained resolution of all identified issues is determined.
- The governing body is responsible to review and analyze all data including monitoring results for issues and trends. Based on the audit results the governing body will make determination as to the frequency of the audits moving forward.
- Inservice sheets are available for review.
- The deficiency was corrected on 4/18/2016

V710 494.150 CFC Responsibilities of the Medical Director

The Medical Director acknowledges his responsibility to:

- Ensure responsibility for oversight to ensure the delivery of quality patient care and to ensure the operation of an effective QAPI program and patient plan of care and Governance.
- Evaluate data collected for revision of improvement plan as necessary until resolution
- Be actively involved in the oversight and implementation of the facilities' policies and procedures for patient assessment, patient plans of care and QAI.
- Evaluate data collected for revision of improvement plan as necessary until resolution

The Governing Body, on 4/12/2016 reviewed the SOD and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The following action steps were implemented.

On 4/18/2016, The Director of Operations will meet with the Medical Director to review with her responsibilities as defined in the Conditions for Coverage, Medical Director's Responsibilities and Professional Staff Bylaws emphasizing her role in ensuring the implementation of performance improvement plans and evaluations of the data collected for revision of improvement plans as necessary until resolution.

The Medical Director as a member of Governing Body will meet weekly to monitor the progress of the Plan of Correction. Continuation of the meetings will be determined by the governing body based on the progress of the plan and that the corrective actions have resulted in resolution of the cited issues. Once sustained resolution is determined by the Governing Body, they will return to quarterly or as needed Governing Body meetings.

Effective immediately:

- A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.
- The Medical Director as chairperson of the QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues

- The Director of Operations (DO) will present a report to the Medical Director on the Plan of Correction and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.
- The Governing Body, at its meeting of 4/18/2016, designated the Quality Dept. to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.
- Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.
- The deficiency was corrected on 4/18/2016

Please note that we will be in compliance by 4/22/16 and will be prepared for you to revisit to assess our clinic for recertification.

Thank you