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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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October 22, 2012

Zachary Phelps, Administrator
Table Rock Dialysis Center
5610 West Gage Street, Suite B
Boise, ID 83706

RE: Table Rock Dialysis Center, Provider #132502

Dear Mr. Phelps:

This is to advise you of the findings of the Medicare survey of Table Rock Dialysis Center, which was conducted on October 19, 2012.

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 **November 4, 2012,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/nw
Enclosures

PRINTED: 10/22/2012
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
	132502	A. BUILDING _____ B. WING _____	10/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABLE ROCK DIALYSIS CENTER	5610 WEST GAGE STREET, SUITE B BOISE, ID 83706

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V 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the survey was: Trish O'Hara, R.N. Acronyms used in this report include: CSS - Clinical Services Specialist EMR - Electronic Medical Record HBV - Hepatitis B virus HBsAg - Hepatitis B surface antigen, indicating the presence of the Hepatitis B virus in the body IDT - Interdisciplinary team PD - Peritoneal Dialysis POC - Plan of Care	V 000	V000 The members of the Governing Body reviewed the Statement of Deficiencies and a Plan of Correction (POC) was developed. The Facility Administrator (FA) acting as the Chief Executive Officer (CEO) will be responsible for implementation of the POC and ongoing compliance. RECEIVED OCT 31 2012 FACILITY STANDARDS	
V 124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This STANDARD is not met as evidenced by: Based on record review, staff interview and review of facility policies, it was determined the facility failed to ensure a patient's Hepatitis B immunity was determined prior to admission for 1 of 1 patients whose records were reviewed and	V 124	V124: The Medical Director will review with each Physician the need for an HBsAg result within 30 days prior to admissions. FA's will also communicate the need to each Physician and Nurse Extender. All HD nurses were re-educated on 10/23/12 on policy 1-05-02 Hepatitis Surveillance, Vaccination and Infection Control Measures to ensure that a copy of an HBsAg result is obtained on each patient prior to admit. Education included, If admission is emergent or they are unable to obtain result, the patient will receive treatment with a single use dialyzer in an area separated from HBV susceptible patients on a dedicated machine. Continued on next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Facility Administrator	10/30/12

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 124	Continued From page 1 who were admitted during the last 6 months. This failure had the potential to negatively impact all patients dialyzing at the facility by exposure to a communicable disease. Findings include: Patient #4 was a 79 year old female who was admitted to the facility on 8/24/12. Review of Patient #4's laboratory results showed no testing had been done prior to her admission to determine her Hepatitis B status. Blood was drawn on the day of her admission to determine this status. In an interview on 10/18/12 at 11:30 AM, the charge nurse stated that if a patient's Hepatitis status was unknown at the time of admission, their treatment was done using a non-reuse dialyzer. She further stated the patient was not placed in the available isolation room and the dialysis machine was not dedicated to that patient. A policy titled "Hepatitis Surveillance, Vaccination and Infection Control Measures," dated March 2011, was reviewed. It stated, in part, "In order to prevent the transmission of Hepatitis B among patients, all new patients should be tested and their HBV serologic status results should be known prior to admission for treatment." A policy titled "Infection Control and Isolation Measures For Known and Suspected Hepatitis B Surface Antigen Positive Patients" and dated September 2010 was reviewed. It stated, in part, "Patients whose Hepatitis B surface antigen status (HBsAg) is unknown will be suspect for Hepatitis B infection until determined otherwise." It further stated "These patients will not	V 124	V124 continued from page 1 The Administrative Assistant (AA)'s will document on a tracking log when patients are admitted with /without prior HBsAg result. This information will be discussed with the Medical Director and documented in the Quality Improvement Meeting Minutes (QIFMM). AA's received training 10/29/12. The FA is responsible for the monitoring and compliance with the Plan of Correction.	10/29/12

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V 124	Continued From page 2 participate in the dialyzer reprocessing program... Patients suspect for Hepatitis B infection will dialyze using a dedicated dialysis delivery system, area, and supplies." The facility failed to determine the communicable disease status of a patient prior to admission.	V 124		
V 416	494.60(d)(4)(iii) PE-CONTACT LOCAL EOC ANNUALLY The facility must- (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure patient safety, in the event of an emergency or disaster, by making patient needs known to the local disaster management agency. This failure had the potential to negatively impact all patients receiving dialysis services at the facility, due to inadequate community response in the case of emergency or disaster. Findings include: During review of the facility's emergency/disaster plan, there was no documentation present indicating communication between the facility and the local disaster management agency. In an interview on 10/18/12 at 4:00 PM, the facility administrator stated he was not aware of any documented contact with the local disaster management agency. He stated the facility was	V 416	V416: The FA will be provided training on policy 4-07-01 Disaster, Fire and Business Continuity Emergency Preparedness Guidelines no later than 10/29/12. Per policy, the facility will update its Emergency and Disaster Plan annually and communicate any changes to the county agency. FA communicated the facility plan in a disaster by phone call to the Board Chairman of the Ada County disaster management agency October 19, 2012. FA will follow up with a letter that includes a copy of the facility disaster plan template. FA will review the disaster management agency's meeting notes quarterly and consider sending a designee to a meeting annually. Any updates to the disaster plan will be approved by Governing Body, reviewed in QIFMM and with all teammates. The Governing body will monitor compliance no less than annually. The FA is responsible for the monitoring and compliance with the Plan of Correction.	10/29/12

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V 416	Continued From page 3 corporately owned and the corporation had a disaster plan, but he was not sure what assistance the corporate disaster representatives would provide to the facility or where the representatives were located. The facility failed to ensure coordination with the local disaster management agency was completed.	V 416		
V 516	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 facility policies, and staff interview, it was determined the facility failed to ensure a comprehensive assessment was completed with 30 days of the initiation of dialysis for 1 of 3 patients (Patient #7) who were using a home modality for dialysis and whose records were reviewed. Failure to complete initial assessments had the potential to result in unmet patient needs. Findings include: Patient #7 was a 76 year old male who had begun in center hemodialysis on 9/8/11. On 1/10/12 he changed modalities to PD. His initial IDT assessment was dated 3/27/12, 76 days after he initiated peritoneal dialysis. In an interview on 10/16/12 at 1:00 PM, the facility CSS stated that a patient who has changed	V 516	V516 FA will review policy 5-01-38 *Patient Assessment and Plan of Care When Utilizing Falcon Dialysis* with PD teammates 10/30/12. FA will re-educate teammates that within 30 days of change in modality the assessment must be complete by the Interdisciplinary Team (IDT). The Assessment Manager will monitor the assessment work list each month and provide a reminder to teammates that haven't completed their modality change assessments. The FA will be notified of all assessments that do not meet the timelines and performance management will be provided. If Falcon, the online computer system is not triggering modality change assessments correctly, verification of correct patient registration admission information will be checked and problems reported to IT as needed. The Assessment Manager will manually trigger a Modality assessment as needed. Results of monthly monitoring by the Assessment Manager will be reviewed in QIFMM meetings. The FA is responsible for the monitoring and compliance with the Plan of Correction.	10/30/12

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V 516	Continued From page 4 dialysis modalities is considered a new patient, and the initial assessment for Patient #7 had not been done in a timely manner. In an interview on 10/16/12 at 11:00 AM, Patient #7's PD nurse stated the computer system for EMRs usually triggered a notification for assessment due dates. She stated the system had failed to trigger a notification for Patient #7's assessment. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," dated September 2012, was reviewed. It contained a table showing the implementation dates for assessments and POCs. It stated that, in the case of a patient who changed dialysis modalities, an assessment should be done within 30 calendar days. The facility failed to provide an initial assessment for Patient #7 within the first 30 days of his PD treatment.	V 516		
V 517	494.80(b)(2) PA-F/U REASSESSMENT-WITHIN 3 MO OF INITIAL A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90. This STANDARD is not met as evidenced by: Based on review of medical records and facility policies, and staff interview, it was determined the facility failed to ensure a comprehensive reassessment was completed with 90 days of the	V 517	V517: FA will review policy 5-01-38 *Patient Assessment and Plan of Care When Utilizing Falcon Dialysis* with teammates 10/30/12. FA will re-educate teammates that re-assessment must be initiated on day 91 and completed within 30 days. Annual re-assessment must be completed 1 year after the 90 day assessment and ongoing annually. continued on next page	

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V 517	Continued From page 5 initial assessment for 1 of 3 patients (Patient #7) who were using a home modality for dialysis and whose records were reviewed. Failure to complete reassessments had the potential to result in addressing changes in patient needs. Findings include: Patient #7 was a 76 year old male who had begun in center hemodialysis on 9/6/11. On 1/10/12 he changed modalities to PD. His initial IDT assessment was dated 3/27/12. The next comprehensive reassessment, done by the IDT for Patient #7, was dated 7/24/12, 148 days after his initial assessment. In an interview on 10/16/12 at 1:00 PM, the facility CSS confirmed Patient #7's reassessment had not been done within 90 days of his initial assessment. In an interview on 10/16/12 at 11:00 AM, Patient #7's PD nurse stated the computer system for EMRs usually triggered a notification for reassessment due dates. She stated the system had failed to trigger a notification for Patient #7's reassessment. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," dated September 2012, was reviewed. It contained a table showing the implementation dates for assessments and POCs. It stated a 90 day reassessment should be initiated on a patient's 91st treatment day and completed within 30 days. The facility failed to provide a comprehensive reassessment for Patient #7 within 90 days of his initial assessment.	V 517	V517 continued from page 5 The Assessment Manager will monitor the assessment work list each month and provide a reminder to teammates that haven't completed their 90 day and annual assessments. The FA will be notified of all assessments that do not meet the timelines and performance management will be provided. If Falcon is not triggering 90 day or annual assessments correctly, problems will be reported to IT. The Assessment Manager will manually trigger the appropriate assessment as needed. Results of monthly monitoring by the Assessment Manager will be reviewed in QIFMM meetings. The FA is responsible for the monitoring and compliance with the Plan of Correction.	10/30/12

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V 519	494.80(d)(1) PA-FREQUENCY REASSESSMENT-STABLE 1X/YR In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- (1) At least annually for stable patients; This STANDARD is not met as evidenced by: Based on review of medical records and facility policies, and staff interview, it was determined the facility failed to ensure a comprehensive reassessment and revision of the POC was completed annually for 1 of 3 patients (Patient #4) who used a home modality for dialysis and whose records were reviewed. Failure to complete reassessments and revise POCs had the potential to result in unmet patient needs. Findings include: Patient #5 was a 61 year old male who had been utilizing home hemodialysis since 6/21/11. His medical record contained documentation of a reassessment and revision of the POC on 8/19/11. The current annual reassessment was dated and signed by the IDT on 10/15/12, 57 days after an annual comprehensive reassessment was due. In an interview on 10/16/12 at 1:00 PM, the facility CSS confirmed Patient #5's reassessment had not been done within one year of his last assessment.	V 519	V519 FA will review policy 5-01-38 *Patient Assessment and Plan of Care When Utilizing Falcon Dialysis* with teammates 10/30/12. FA will re-educate teammates that annual re-assessment must be completed 1 year after the 90 day assessment and ongoing annually. The Assessment Manager will monitor the assessment work list each month and provide a reminder to teammates that haven't completed their annual assessments. The FA will be notified of all assessments that do not meet the timelines and performance management will be provided. If Falcon is not triggering annual assessments correctly, problems will be reported to IT. The Assessment Manager will manually trigger the appropriate assessment as needed. Results of monthly monitoring by the Assessment Manager will be reviewed in QIFMM meetings. The FA is responsible for the monitoring and compliance with the Plan of Correction.	10/30/12

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V 519	Continued From page 7 In an interview on 10/16/12 at 11:00 AM, Patient #5's home hemodialysis nurse stated the computer system for EMRs usually triggered a notification for reassessment due dates. She stated the system had failed to trigger a notification for Patient #5's reassessment. A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," dated September 2012, was reviewed. It stated the annual reassessment was to be done, "1 year after the 90 day reassessment. Ongoing annual reassessments will be completed 1 year after the annual reassessment or unstable reassessment." The facility failed to complete an annual comprehensive reassessment of Patient #5 in a timely manner.	V 519		