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

May 15, 2013

Dana Camacho, Administrator
Treasure Valley Dialysis Center
3525 East Louise Drive, Suite 155
Meridian, ID 83642

RE: Treasure Valley Dialysis Center, Provider #132513

Dear Ms. Camacho:

This is to advise you of the findings of the Medicare survey of Treasure Valley Dialysis Center, which was conducted on May 9, 2013.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **May 28, 2013,** 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/pt
Enclosures

PRINTED: 05/14/2013
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3526 EAST LOUISE DRIVE, SUITE 155 MERIDIAN, ID 83642

(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 RECEIVED MAY 28 2013 [CORE] FACILITY STANDARDS The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: EDW - Estimated Dry Weight FA - Facility Administrator Kg - Kilogram QAPI - Quality Assurance Performance Improvement QIFMM - Quality Improvement Facility Management Meetings	V 000	V000 The Governing Body of Treasure Valley Dialysis has reviewed the Statement of Deficiency from the Recertification CORE Survey held on May 9, 2013. The Governing Body approves and submits the following plan of correction.	
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 the POC was implemented by addressing volume status for 2 of 3 patients (Patients #2 and #3,) whose treatment records were reviewed. This failure resulted in patients not attaining their prescribed dry weight and being put at risk of complications resulting from fluid overload. Findings include: In an interview on 5/8/13 at 10:00 a.m., the facility's Regional Educator stated it was facility	V 543	V 543 The facility's daily tracking sheets for Estimated Dry Weights (EDWs) have been modified and will be used for the whole week. The facility will track EDWs daily and weekly for each group of patients MWF and TTS. Tracking sheets will be used to audit patient's EDW at the end of the day and track trends throughout the week and month. RNs will notify MD/NP about trends and document findings with action plan in Plan of Care notes. These EDW daily sheets will also be reviewed at Interdisciplinary Team Meeting as well as in monthly Quality (QIFMM) meetings. Direct patient care teammates, Dietician and Social Worker will receive education from Clinical Services Specialist (CSS) and Facility Administrator (FA) on proper Plan of Care documentation to include an intervention with timeline. Registered Dietician and Social Worker will provide additional focus during IDT meetings with assessment on identified patient volume status and documentation of education/counseling will be added to notes by each discipline. FA is responsible for monitoring and compliance.	5/28/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Group Facility Administrator	5/27/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3525 EAST LOUISE DRIVE, SUITE 155 MERIDIAN, ID 83642

(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 1	V 543		

policy that a patient's EDW was acceptable if it was 1 kg more or less than the EDW established in the POC.

a. Patient #2's record showed a 64 year old male with diagnoses including ESRD and Type 2 Diabetes. His currently prescribed EDW was 109 kg. Sixteen dialysis treatments were reviewed from 4/1/13 - 5/6/13. Post treatment documentation showed Patient #2 did not attain an EDW within 1 kg of his prescribed EDW during nine of sixteen, or 56%, of treatments reviewed as follows:

Date	EDW	Post weight
4/10/13	109 kg	110.4 kg
4/17/13	109 kg	112.9 kg
4/19/13	109 kg	111.2 kg
4/22/13	109 kg	111.8 kg
4/24/13	109 kg	111.8 kg
4/26/13	109 kg	111.6 kg
4/29/13	109 kg	112.6 kg
5/1/13	109 kg	112.0 kg
5/6/13	109 kg	111.5 kg

Post treatment notes for five treatments, dated 4/10/13, 4/22/13, 4/24/13, 4/26/13, and 5/6/13 contained a repetitive but ineffective corrective action plan instructing the patient to restrict oral fluids between treatments.

One post treatment note, dated 4/17/13, stated staff had failed to set the fluid removal value on the machine, resulting in no fluid being removed during that day's treatment. An additional treatment was offered the following day but Patient #2 "refused due to another MD

PRINTED: 05/14/2013
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3525 EAST LOUISE DRIVE, SUITE 165 MERIDIAN, ID 83642

(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 2	V 543		

appointment at the same time we had available."

In an interview on 5/8/13 at 10:00 a.m., the facility's Regional Educator confirmed Patient #2 had not attained his prescribed EDW during nine of sixteen treatments.

b. Patient #3's record showed a 71 year old female with diagnoses including ESRD and Type 2 Diabetes. Her currently prescribed EDW was 70 kg until 5/1/13 when it was increased to 70.5 kg. Post treatment documentation showed Patient #3 did not attain an EDW within 1 kg of her prescribed EDW during seven of sixteen, or 44%, of treatments reviewed as follows:

Date	EDW	Post weight
4/22/13	70 kg	71.5 kg
4/24/13	70 kg	71.9 kg
4/26/13	70 kg	71.4 kg
4/29/13	70 kg	73.2 kg
5/1/13	70.5 kg	72.2 kg
5/3/13	70.5 kg	72.2 kg
5/6/13	70.5 kg	72.3 kg

Post treatment notes for three treatments, dated 4/24/13, 4/29/13, and 5/6/13, contained a repetitive but ineffective corrective action plan instructing the patient to restrict oral fluids between treatments. No documentation showed extra dialysis treatments were offered to Patient #3 for fluid removal.

In an interview on 5/8/13 at 10:00 a.m., the facility's Regional Educator confirmed Patient #3 had not attained her prescribed dry weight during seven of sixteen treatments.

PRINTED: 05/14/2013
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3525 EAST LOUISE DRIVE, SUITE 165 MERIDIAN, ID 83642

(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 3 The facility failed to consistently address patients' volume status.	V 543		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Based on QAPI documentation review and staff interview, it was determined the facility failed to ensure all facility patient outcomes were evaluated, including volume status. This failure put all patients at risk of complications related to fluid overload. Findings include: The facility's QAPI monthly data collection and meeting minutes were reviewed for the six month period November, 2012 - April, 2013. The data was collected in a required format developed by the facility's corporate leadership. Review showed no data was required to be collected to indicate the facility's performance relating to patients' volume status. Additionally, the format included a section for facilities to collect data, identify performance issues, and develop action plans specific to their own facility needs. Review showed the facility had not used this capability to track data related to patients' volume status.	V 628	V628 IDT including Medical Director will receive education from CSS on policy 1-14-06 CONTINUOUS QUALITY IMPROVEMENT PROGRAM. Focus of education will be on the requirement for the facility to identify, analyze and trend patient outcomes including volume status. Volume status has been added to the facility specific indicators for review in the Interdisciplinary Team Meetings. The daily and weekly EDW tracking sheets and volume status indicators will ba brought to the monthly QIFMM meetings for review. The new process and indicators were reviewed at QIFFM meeting on 5/28/13. FA is responsible for monitoring and compliance.	5/28/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PRINTED: 05/14/2013
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
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3525 EAST LOUISE DRIVE, SUITE 155 MERIDIAN, ID 83642

(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 628	Continued From page 4 In an interview on 5/8/13 at 3:00 p.m., the facility administrator confirmed no data was collected to assess facility performance relative to patients' volume status. The facility failed to comprehensively evaluate and review patient outcomes.	V 628		
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 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 all facility patients at risk of inadequate dialysis due to lack of continual patient health outcome reviews. Findings include: Facility QIFMM meetings were held at the facility the fourth Tuesday of each month. The facility's monthly QAPI data collection and meeting minutes were reviewed for the six month period November, 2012 - April, 2013. An attendance signature form was attached to each month's minutes. This form had an area for signature indicating attendance of the medical director, as well as an area for signature indicating review of the month's QAPI data in lieu of meeting attendance. The medical director's signature was absent in both areas of the form, indicating he had not attended the meeting or reviewed facility	V 712	V712 The Medical Director will be provided a review of the policy 3-03-77 QUALITY IMPROVEMENT AND FACILITY MANAGEMENT MEETING PROCESS. Education focus will be that if the Medical Director is unable to attend the QIFMM meeting, the FA will forward on the minutes to him and his scheduler at his primary office location for review. When physician is in house to round next he will sign the meeting minutes form. The Medical Director will be reminded attendance at the QIFMM meeting can be via telephone conference attendance. The Clinical Coordinator and FA will audit this process monthly and review in monthly QIFMM meeting. This process was reviewed at QIFMM on 5/28/13. FA and Medical Director are responsible for monitoring end compliance.	5/28/13

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

PRINTED: 05/14/2013
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
	132513	A. BUILDING _____ B. WING _____	05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREASURE VALLEY DIALYSIS CENTER	3525 EAST LOUISE DRIVE, SUITE 155 MERIDIAN, ID 83642

(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 5 QAPI data, for three of six monthly meetings reviewed including November 2012, March 2013, and April 2013. A policy titled "Quality Improvement And Facility Management Meeting Process," revised May, 2013, stated, "QIFMMs are normally conducted monthly, and no less than quarterly. QIFMMs should normally be attended by the FA, the facility Medical Director (MD), Registered Nurse, Registered Dietician, Social Worker, selected clinical teammates, and facility Biomed Tech representatives." The policy went on to say, "The Minutes Form is to be signed by all participants including the MD. If the MD was unable to attend the meeting, the MD must review the minutes with the FA and sign on the designated area of the Minutes Form to document the review." During interviews conducted on 5/8/13 and 5/9/13, two staff stated it was difficult to get the medical director to attend QAPI meetings and to actively participate in the meetings he did attend. The facility failed to ensure the medical director fulfilled his responsibilities required by the QAPI process.	V 712		