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

June 3, 2013

COPY

Melody Nelson, Administrator
Caldwell Dialysis Center
821 South Smeed Pkwy
Caldwell, ID 83605

RE: Caldwell Dialysis Center, Provider #132518

Dear Ms. Nelson:

This is to advise you of the findings of the Medicare survey of Caldwell Dialysis Center, which was conducted on May 21, 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:

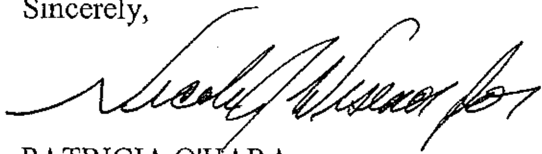
An acceptable plan of correction (PoC) contains the following elements:

- 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.

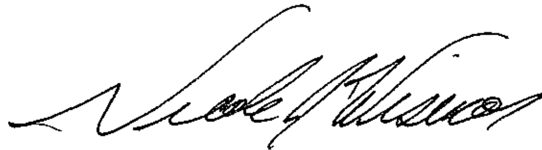
After you have completed your Plan of Correction, return the original to this office by **June 14, 2013,** and keep a copy for your records.

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

Sincerely,



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



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

PO/pt
Enclosures

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

PRINTED: 05/28/2013
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
	132518	A. BUILDING ______ B. WING ______	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALDWELL DIALYSIS CENTER	821 SOUTH SMEED PKWY CALDWELL, ID 83605

(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 CORE recertification survey of your ESRD facility. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: BFR - Blood Flow Rate CSS - Clinical Services Specialist DFR - Dialysate Flow Rate EDW - Estimated Dry Weight EMR - Electronic Medical Record FA - Facility Administrator IDT - Interdisciplinary Team KDOQI - Kidney Disease Outcomes Quality Initiative Kg - Kilogram MD - Medical Doctor ml - Milliliter MSW - Masters prepared Social Worker POC - Plan Of Care QIFM - Quality Improvement Facility Management Note: An expansion of services survey was also conducted at this time. It is recommended the facility be approved for the expansion of services to include Home Hemodialysis Training and Support.	V 000	V000 The Caldwell Dialysis Governing Body has reviewed the Statement of Deficiency for the Recertification survey held on May 21, 2013. The Governing Body approves of the following Plan of Correction.	
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90;	V 463	V463 Caldwell team to include nurses and PCTs were re-trained by Facility Administrator (FA) during monthly team meeting on 5/30/13 regarding length of patient treatment. Training material used was "Hemodialysis - Every Minute Counts!" Continued on next page	

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JUN 13 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nathan Bodily [signature] TITLE: Facility Administrator (X6) DATE: 6/12/13

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.

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V 463	Continued From page 1	V 463		

V 463 — Summary Statement of Deficiencies

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure patients' rights to receive care as outlined in their POC was upheld for 3 of 4 in center hemodialysis patients (Patients #1, #3 and #4) whose treatment records were reviewed. This resulted in patients being left at risk for complications of inadequate dialysis and fluid overload. Findings include:

1. Patient #3 was a 46 year old female who had been dialyzing since 12/9/08. Her current dialysis prescription ordered a 4.25 hour treatment three times a week, with DFR of 600 ml/minute, a BFR of 400 ml/minute, and an EDW of 127.5 kg.

Fifteen treatments between 4/11 - 5/16/13 were reviewed. Patient #3's prescription was not delivered as follows:

a. Patient #3 did not attain her prescribed EDW (+/- 1 kg) for 15 of 15 (100%) treatments reviewed:

Date	EDW	Post weight
4/11/13	127.5 kg	130.3 kg
4/13/13	127.5 kg	129.5 kg
4/16/13	127.5 kg	130.6 kg
4/18/13	127.5 kg	131.0 kg
4/20/13	127.5 kg	130.5 kg
4/23/13	127.5 kg	130.3 kg
4/25/13	127.5 kg	129.2 kg
4/27/13	127.5 kg	128.9 kg
4/30/13	127.5 kg	76.0 kg
5/04/13	127.5 kg	129.1 kg

V 463 — Provider's Plan of Correction

Training reviewed the responsibility of assisting patients in receiving their full ordered treatment and emphasized the importance of following the physician orders. Additional training was held on 6/10/2013 to ensure that settings for blood flow rate (BFR), dialysis flow rate (DFR), and estimated dry weight are properly followed per physician orders. This in-service also included a review of policy #1-03-09 "Intradialytic Treatment Monitoring" with emphasis placed on: 1) Reporting significant changes to the licensed nurse. 2) All appropriate action being documented. 3) Licensed nurse will notify the physician as needed of changes. 4) Documentation will be included in patient's medical record. To ensure the plan of correction is effectively implemented the FA will complete a post treatment audit on every patient during the month of June 2013. Moving forward, monthly post treatment audits will be completed by the FA on 10% of facility patients. Results of the post treatment audits will be discussed with the Medical Director during Quality meetings. The FA and clinical coordinator are responsible for this plan of correction.

Completion date: 6/21/13

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V 463	Continued From page 2	V 463		

5/07/13	127.5 kg	131.1 kg
5/09/13	127.5 kg	131.4 kg
5/11/13	127.5 kg	131.5 kg
5/14/13	127.5 kg	130.5 kg
5/16/13	127.5 kg	129.4 kg

Documentation showed Patient #3 had been offered extra treatment time two of the fifteen times she had excess fluid post treatment.

b. Patient #3 did not receive prescribed treatment time for 9 of 15 (59%)treatments reviewed:

Date	RX time	Actual time
4/13/13	255 min.	225 min.
4/18/13	255 min.	223 min.
4/20/13	255 min.	245 min.
4/23/13	255 min.	231 min.
4/25/13	255 min.	248 min.
4/30/13	255 min.	228 min.
5/04/13	255 min.	243 min.
5/07/13	255 min.	246 min.
5/09/13	255 min.	193 min.

This reflected an accumulated 213 minutes of lost dialysis time during a one month period.

During this time Patient #3's adequacy of dialysis, as measured by Kt/V, decreased from 1.51 on 4/11/13 to 1.13 on 5/16/13. KDOQI standards recommended acceptable adequacy as a measurement above 1.2.

During an interview on 5/10/13 from 3:00 - 5:00 p.m., the CSS reviewed treatments and confirmed the incorrect delivery of prescribed treatments for Patient #3.

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V 463	Continued From page 3	V 463		

2. Patient #1 was a 75 year old male who had been dialyzing since 9/28/10. His prescription ordered a 3 hour treatment two times a week, with a DFR of 600 ml/minute, a BFR of 500 ml/minute, and an EDW of 94.5 kg.

Eleven treatments, from 4/11/13 - 5/16/13, were reviewed. Patient #1's dialysis was inadequate as evidenced by a Kt/V of 1.08 on 4/11/13. Patient #1 refused to increase his treatment time or frequency. On 4/25/13 the M.D., in an effort to improve Patient #1's adequacy, prescribed an increased DFR to 800 ml/minute, and an increased BFR to 550 ml/minute.

Patient #1 did not receive prescribed DFR/BFR for 4 of 7 (57%) of the treatments reviewed, from 4/25/13 - 5/16/13, for the new prescription as follows:

- 5/02/13: RX BFR was 550, actual BFR was 450.
- 5/07/13: RX DFR was 800, actual DFR was 500.
- 5/16/13: RX BFR was 550, actual BFR was 340.
- 5/09/13: RX DFR was 800, actual DFR was 600.

During an interview on 5/10/13 from 3:00 - 5:00 p.m., the CSS reviewed treatments and confirmed the incorrect delivery of prescribed treatments for Patient #1.

3. Patient #4 was a 37 year old female who had been dialyzing at the facility since 12/10/12. Her prescription ordered a 4 hour treatment three times a week with a DFR of 600 ml/minute, a BFR of 400 ml/minute, and an EDW of 57 kg. BFR was ordered as 425 ml/minute on 5/1/13.

Twelve treatments, from 4/20/13 - 5/16/13, were

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V 463 Continued From page 4

reviewed. Patient #4 did not receive prescribed DFR/BFR for 4 of 12 treatments reviewed:

- 4/23/13: RX BFR was 400, actual BFR was 350.
- 5/04/13: RX BFR was 425, actual BFR was 250 and RX DFR was 600, actual DFR was 500.
- 5/09/13: RX BFR was 425, actual BFR was 305-400.
- 5/11/13: RX DFR was 600, actual DFR was 500.

Additionally, Patient #4 did not receive prescribed treatment time for 3 of 12 treatments reviewed.

Date	RX Time	Actual Time
4/23/13	240 min.	185 min.
5/04/13	240 min.	206 min.
5/11/13	240 min.	214 min.

Accumulated lost time was 115 minutes during a 26 day period.

During an interview on 5/10/13 from 3:00 - 5:00 p.m., the CSS reviewed treatments and confirmed the incorrect delivery of prescribed treatments for Patient #4.

The facility did not uphold patients' rights to dialysis treatments as prescribed.

V 463

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;

V 519

V519
Patient #1 will have Plan of Care updated by the Interdisciplinary team (IDT). FA will review policy 1-14-02 PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS with IDT on 6/11/13. FA will give each member of the IDT a copy of "Falcon Dialysis Training Script - Assessments and Plan of Care" on 6/11/13 to be used as a reference guide for future assessments and care plans.

Continued on next page

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V 519	Continued From page 5 This STANDARD is not met as evidenced by: Based on review of medical records and facility policy, 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 4 patients (Patient #1) whose records were reviewed. Failure to complete reassessments and revise POCs had the potential to result in unidentified and unaddressed patient needs. Findings include: A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," dated 3/2011 and revised 9/2011, 9/2012, and 3/2013 stated "A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients..." Patient #1 was a 75 year old male who started dialysis on 9/28/10. His current medical condition was considered to be stable. A reassessment and updated POC was documented on 2/8/12. A subsequent reassessment and updated POC was documented on 5/15/13, with fifteen months transpiring between the two reassessments and revised POCs. In an interview on 5/20/13 at 11:00 a.m., the facility CSS confirmed the time lapse between the two documents. The facility failed to assess and revise a POC, for a stable patient, on an annual basis.	V 519	FA has assigned Registered Dietician (RD) as Caldwell's Assessment Manager. RD completed class FDA 1005 "Assessment Manager Overview" on 6/7/13. The Assessment Manger will monitor the assessment work list on a monthly basis and provide a reminder to the members of the IDT to complete work before the monthly IDT meetings. Additionally, the assessment manager will bring the "Future Assessments Report" to each IDT meeting showing upcoming patients that need to be completed. FA discussed with Assessment Manager on 6/6/13 that all documentation is printed before the IDT meeting to ensure that all members are able to sign. The FA will be notified if any member of the IDT fails to meet the monthly timeline. If Falcon (an online computer generated Assessment and Plan of Care program) fails to correctly populate patients who are due for an assessment and plan of care, issues will be reported to the DaVita IT Helpdesk as needed. In these cases the assessment manager will manually trigger the process. For monitoring purposes, a 10% medical record audit will be completed quarterly and results will be reviewed in the Quality meeting with the Medical Director. The Assessment Manager and FA are responsible for this plan of correction.	6/21/13
V 520	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO	V 520	V520 Continued on next page	

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V 520	Continued From page 6 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- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations; (ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. This STANDARD is not met as evidenced by: Based on staff interview, record review, and facility policy review, it was determined the facility failed to ensure a patient, who had been classified as unstable, was reassessed and had POC revisions on a monthly basis. This directly impacted 1 of 4 patients (Patient #3), whose records were reviewed, and resulted in a patient's deteriorating health status not being appropriately addressed. Findings include: A policy titled "Patient Assessment and Plan of Care When Utilizing Falcon Dialysis," dated 3/2011 and revised 9/2011, 9/2012, and 3/2013 stated "A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: At least annually for stable patients and at least monthly for unstable patients including, but not limited to, patients with the following: Extended or frequent hospitalizations;	V 520	V520 Patient #3 will be re-assessed by IDT to determine Stable/Unstable status with new Plan of Care as indicated by assessment. FA will review policy #1-14-02 PATIENT ASSESSMENT AND PLAN OF CARE WHEN UTILIZING FALCON DIALYSIS with IDT on 6/11/13; specific attention will be placed on 30 day timeline for unstable patients. FA will in-service IDT team using "Guideline for Unstable Criteria for Interdisciplinary Assessments and Plan of Care" on 6/11/13. Each month during IDT meeting each patient will be review for stable/unstable status. The Assessment Manger will monitor the assessment work list for "unstable" on a monthly basis and provide a reminder to the members of the IDT to complete work before the monthly IDT meetings. FA discussed with Assessment Manager on 6/6/13 that all documentation is printed before the IDT meeting to ensure that all members are able to sign. The FA will be notified if any member of the IDT fails to meet the monthly timeline. If Falcon (an online computer generated Assessment and Plan of Care program) fails to correctly populate unstable patients who are due for an assessment and plan of care, issues will be reported to the DaVita IT Helpdesk as needed. In these cases the assessment manager will manually trigger the process. For monitoring purposes, a 10% medical record audit will be completed quarterly and results will be reviewed in the Quality meeting with the Medical Director. The Assessment Manager and FA are responsible for this plan of correction.	6/21/13

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V 520	Continued From page 7 Marked deterioration in health status; Significant changes in psychosocial needs; Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis." Patient #3 was a 46 year old female who had been dialyzing since 12/9/08. Review of her medical record showed she had been deemed "unstable" by the IDT on 6/7/12 , due to frequent hospitalizations. Reassessment and revision of Patient #3's POC occurred on 8/23/12, 11/26/12, and 5/7/13. No reassessment or POC revision was documented for Patient #3 during the months of 7/12, 9/12, 10/12, 12/12, 1/13, 2/13, 3/13, or 4/13. Additionally, review of the facility's hospitalization log showed Patient #3 had continued to have frequent hospitalizations, documented on 12/24/12, 2/4/13, 2/9/13, 2/18/13, 3/28/13, and 5/1/13. In an interview on 5/21/13 at 11:00 a.m., the facility MSW confirmed Patient #3 had not been reassessed and her POC had not been revised on a monthly basis. She said the facility's EMR system was designed to identify patients who had assessments/POCs due and alert IDT members, but it had failed to do so. The facility failed to assess and plan care for an unstable patient on a monthly basis.	V 520		
V 554	494.90(a)(7)(ii) POC-TRANSPLANT STATUS PLAN OR WHY NOT When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The	V 554	V554 On 6/6/13 FA completed in-service with facility Social Worker regarding prompt and detailed documentation of transplant status in Falcon. On 6/10/13 the Regional Social Worker Lead will complete a review of policy #1-14-08 "Transplant Review and Tracking Process" with facility Social Worker. Continued on next page	

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V 554	Continued From page 8 patient's plan of care must include documentation of the- (A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with §494.80(a)(10). This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure transplant status was accurately documented and a plan developed in the POC for 2 of 4 patients (Patients #3 and #4) whose records were reviewed. This resulted in the failure of patients to proceed through the process of transplant referral, work up, and wait time on the transplant list. Findings include: Patients' POCs were documented on a required format developed by the facility's corporate leadership. Thirty five goals were addressed, each with three columns marked Category, Condition, and Met/Not met. Category and Condition columns were pre-printed and could not be changed by the IDT. The Met/Not met column was filled in by members of the IDT as patient assessments were completed. Goals that were marked as not met had a plan developed by the IDT directed toward attaining the goal. Goals that were marked as met were not addressed by the IDT. The records of Patients #3 and #4 were reviewed	V 554	On a go forward basis, the facility Social Worker will make use of the transplant Plan of Care (POC) & progress note section of Falcon to track education and progress of patients pursuing transplant. These POC & progress notes will also be used to document patients with no interest in transplant and those who the physician feels do not meet criteria as outlined by the transplant centers. Patient #3 and #4 progress notes have been updated regarding transplantation. Once complete the transplant POC will become part of the patients' printed Plan of Care and reviewed as part of the monthly interdisciplinary team (IDT) meeting. The transplant plan of care goal will be left as "unmet" for all patients with exception of those who are active on the transplant list, have been educated and have stated they are not interested in transplant, and those the physician states are not a candidate. Patients in the "unmet" category will be followed up and educated by the facility social worker every 90 days. During the admissions and initial patient education process, the facility Social Worker will provide each patient with the DaVita handout, "DaVita Celebrates and Supports Transplantation." This education will be documented in each patients transplant progress note. To prevent reoccurrence, a 10% audit of patient progress notes for transplant evaluation, candidacy, and education will be performed quarterly and the results will be reported in the "Facility Specific" section of the monthly Quality meeting minutes. This information will be reviewed with the Medical Director. The Social Worker and FA are responsible for this plan of correction.	6/21/13

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	132518	A. BUILDING ______ B. WING ______	05/21/2013

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V 554	Continued From page 9 and documented the following: a. Patient #3 was a 46 year old female who had been dialyzing since 12/9/08. Her POC contained the 35 pre-printed goals in the corporate format. One goal addressed Transplant under the Category column. The Condition column read "Maintain Candidacy or reason for other status." Patient #3's POC, dated 11/26/12, documented this goal as having been met. Patient #3's record contained a letter from a transplant center, dated 8/27/09, showing she had been evaluated by the center and would be re-evaluated for transplant status after she had lost a specific amount of weight. She was progressing toward this goal and had lost 70 pounds. b. Patient #4 was a 37 year old female who had been dialyzing at the facility since 12/10/12. Her POC contained 35 pre-printed goals in the corporate format. One goal addressed Transplant under the Condition column. The Condition column read "Maintain Candidacy or reason for other status." Patient #4's POC, dated 3/6/13, documented this goal as having been met and no plan had been developed to assist Patient #4 toward her goal of transplantation. Patient #4's record contained a letter from one transplant center, dated 2/4/13, stating she had been denied for transplant work up. A progress note, dated 2/5/13 and entered by the MSW, showed Patient #4 had requested a referral to another specific transplant center for consideration for work up.	V 554		

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V 554	Continued From page 10 When asked on 5/21/13 at 12:00 p.m., the MSW stated she was responsible for determining patients' transplant goals as met/not met on POCs. She said she had changed her mind about how to determine whether patients had met this goal after recently reading the training instructions. She said the instructions directed her to mark a patient's transplant goal as met if the patient had been educated that transplant was a treatment option. She stated because Patient #3 had been educated that transplant was a treatment option, the MSW had marked her transplant status to goal met. Subsequently, a plan was not developed to assist Patient #3 toward her goal of transplantation. The MSW further stated because Patient #4 had been educated that transplant was a treatment option and she had been denied by one transplant center, the MSW had changed Patient #4's transplant status to goal met. The MSW said she had not followed up on Patient #4's request and a referral to another specific transplant center had not been made. During the same interview the FA, the CSS, and the charge nurse said the POC format did not allow for accurately addressing an individual patient's current transplant status or for developing a plan for pursuing transplantation. The facility failed to accurately assess transplant status and develop a plan for pursuing transplantation for Patients #3 and #4.	V 554		
V 628	494.110(a)(2) QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS The dialysis facility must measure, analyze, and	V 628	V628 Continued on next page	

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V 628	Continued From page 11 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 review of QIFM documentation and patient POCs and staff interview, it was determined the facility failed to ensure all patient outcomes were evaluated, including fluid management for 1 of 4 in center hemodialysis patients (Patient #3) whose treatment records were reviewed. This failure put all patients dialyzing at the facility at risk of complications related to fluid overload. Findings include: 1. Patient #3 was a 46 year old female who had been dialyzing since 12/9/08. Her current dialysis prescription ordered a 4.25 hour treatment three times a week and an EDW of 127.5 kg. Fifteen treatments between 4/11 - 5/16/13 were reviewed and documented Patient #3 did not attain her prescribed EDW (+/- 1 kg) for 15 of 15 (100%) treatments reviewed. The facility's QIFM monthly data collection and meeting minutes were reviewed for the four month period January 2013 - 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' fluid management. Additionally, the format included a section for facilities to collect data, identify performance	V 628	V628 On 6/11/13, Caldwell FA will review with the interdisciplinary team (IDT) and Medical Director Policy 1-14-06 CONTINUOUS QUALITY IMPROVEMENT PROGRAM and policy 1-03-12 POST TREATMENT PATIENT ASSESSMENT. The in-service will focus on the requirement for the facility to identify, analyze and trend patient volume status. A facility specific report will be created in Snappy (DaVita's online clinical application) that will track adherence to dry weight. This report will be reviewed monthly during the IDT meetings and will be reported to the medical director using the "facility specific" section of the Quality Improvement Facility Meeting Minutes (QIFMM) template. This new process and indicators will be reviewed starting at the June 2013 Quality meeting on 6/17/13. FA is responsible for monitoring and compliance.	6/21/13

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V 628	Continued From page 12 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' fluid management. In an interview on 5/21/13 at 1:00 p.m., the FA confirmed no data was collected to assess facility performance relative to patients' fluid management. The facility failed to comprehensively evaluate and review patient outcomes.	V 628		