IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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July 18, 2014

Kent Church, Administrator
Yellowstone Dialysis Center
1165 Summers Drive
Rexburg, ID 83440

RE: Yellowstone Dialysis Center, Provider #132510

Dear Mr. Church:

This is to advise you of the findings of the Medicare survey of Yellowstone Dialysis Center, which was conducted on July 10, 2014.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **July 30, 2014,** and keep a copy for your records.

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

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132510	A. BUILDING _____ B. WING _____	07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE DIALYSIS CENTER	1165 SUMMERS DRIVE REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 7/7/14 - 7/10/14. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: EDW - Estimated Dry Weight ICHD - Incenter hemodialysis kg - kilogram	V 000	RECEIVED JUL 30 2014 FACILITY STANDARDS	
V 122	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure infection control standards were implemented during the clean-up of accidental blood spills. This failure had the potential to impact 22 patients (Patients #1 - #22) dialyzing at the facility, as well as staff members and visitors, by allowing cross contamination from blood to surfaces within the facility. Findings include: A policy titled "Surface Cleaning Of The Dialysis	V 122	It is the policy of the Yellowstone Dialysis Center (YDC) to clean and disinfect surfaces and equipment based on written protocols – further if items or surfaces are visibly contaminated with blood a tuberculocidal disinfectant is to be used to clean and disinfect. Blood spills in the treatment and other areas, such as the waiting room and patient bathroom, need to be cleaned effectively and immediately. The YDC Facility Manager will conduct an inservice on July 16, 2014 with all the YDC staff on the following: 1) Review Dialysis Program Policy and Procedure section IV No:B-11 (see attachment A); 2)	08/30/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Helen L. Hemmy — TITLE: Director — (X6) DATE: 7/29/2014

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 122	Continued From page 1 Unit," dated 10/17/2008, included the following information: "PROCEDURE: Environmental surfaces (machine surface; blood spills; patient chairs; walls; sinks; counters; floors; exterior of reused dialyzers; 1. Mix an approved tuberculocidal hospital grade disinfectant according to manufacturers [sic] instructions. 2. Apply using a spray bottle or a soaked cloth. 3. Do not rinse. Allow for the manufacturers recommended contact time. 4. Wipe down after contact time is met." During an observation on 7/9/14 from 8:30 - 11:45 A.M., Patient #4, a visiting patient, was noted to complete his dialysis treatment. His left upper extremity access was wrapped with a pressure dressing. However, on his way to the lobby area the access began to bleed, leaving blood on the floor of the outer hallway. Patient #4 returned to the treatment area for assistance. A dialysis technician was observed to wet several cloths with tap water from a sink and proceeded to wipe up the blood in the outer hallway. No disinfectant was observed to be used for the cleaning. When asked, at the time of the observation, the technician said the cleaning probably should have been done with bleach water. In an interview on 7/10/14 at 10:00 A.M., the Nurse Manager confirmed the policy's direction and said the blood spill should have been cleaned with a disinfectant as directed. The facility failed to ensure infection control precautions were followed.	V 122	Each staff member is to read and sign policy page to verify having been re-trained on the subject; 3) YDC Facility Manager will monitor each member daily commencing on July 30, 2014 thru August 30, 2014 to ensure all surfaces and equipment in the YDC are disinfected according to policy. Documentation of these audits will be on Attachment B; 4) YDC Facility Manager will place bottles of Wexide at each sink and under the ice machine for ready access to staff in case of blood spills by July 16, 2014.	08/30/2014

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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 volume status was managed for 1 of 3 ICHD patients (Patient #3) whose treatment records were reviewed. This failure resulted in a patient not attaining his prescribed dry weight and being put at risk of complications resulting from fluid overload. Findings include: Patient #3 was a 43 year old ICHD patient. His dialysis prescription included five hour treatments, three times a week, and his EDW was 160 kg. Thirteen treatment records from 6/11/14 - 7/7/14 were reviewed. Thirteen of the thirteen records indicated Patient #3 did not achieve his EDW as follows: Date / Prescribed EDW / Actual post weight 6/11/14 160 kg 170.4 kg 6/13/14 160 kg 170.2 kg 6/16/14 160 kg 172.2 kg 6/18/14 160 kg 172.6 kg 6/20/14 160 kg 173.2 kg 6/23/14 160 kg 173.5 kg 6/24/14 160 kg 170.5 kg 6/25/14 160 kg 167.8 kg 6/27/14 160 kg 168.0 kg 6/30/14 160 kg 170.3 kg 7/02/14 160 kg 170.8 kg 7/05/14 160 kg 170.6 kg	V 543	It is the policy of YDC for the Primary Care Team to address all patients' volume status on an ongoing basis. This will assure that patients meet their estimated dry weight. Assessment and documentation are input in each patient's Plan of Care, monthly progress notes and on the patients' individual dialysis run sheet. YDC Facility Manager and Primary Care Nephrologist of patient #3 cited in the YDC Survey on 7/11/2014 will implement the following effective 7/11/2014. 1) provide additional treatments for 2 weeks (#5); 2) increase treatments to #6/week if target goal of 164 KG isn't met; 3) reassess in patient #3's Plan of Care and document; 4) provide extra treatments as ordered; 5) coordinate with Gem State Dialysis if needed for extra treatments; 6) monitor intradialytic B/P closely to ensure patient safety while removing large amounts of	11/04/2014

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V 543	Continued From page 3 7/07/14 160 kg 168.7 kg This represented an average post dialysis weight of 10.7 kg above prescribed EDW. Additionally, 15 treatments were reviewed from 5/2/14 - 5/30/14. During this time period Patient #3's prescribed EDW was 158 kg and his average post dialysis weight was 171.4 kg, 13.4 kg above prescribed EDW. Further, 12 treatments were reviewed from 4/2/14 - 4/30/14. During this time period Patient #3's prescribed EDW was 158 kg and his average post dialysis weight was 166.5 kg, 8.5 kg above prescribed EDW. Extra treatments were delivered to Patient #3 on 5/20/14, 5/29/14, and 6/24/14. There was no documentation showing other additional dialysis time was offered or delivered to Patient #3, and no changes were made to his dialysis prescription, in an effort to remove excess fluid during a 90 day period. In an interview on 7/10/14 at 10:00 A.M., the Nurse Manager confirmed Patient #3's continued failure to attain prescribed EDW. He said no additional treatments had been delivered and no changes had been made to Patient #3's dialysis prescription in an effort to remove excess fluid. The facility failed to manage Patient #3's volume status.	V 543	fluid; 7) educate patient as needed on fluid control and assist patient with interdialytic weight gain goals; 8) reassess current Plan of Care to address fluid status goals and interventions required to meet stated goals; 9) document extra treatments, estimated dry weights and achievement of set goals on monthly notes. The Facility Manager of YDC will utilize Attachment C starting August 4, 2014 to document and assure that all patients at YDC have accurate volume status and that this reflects the current orders and is assessed on an ongoing basis in the Plan of care. This audit will be conducted daily by the YDC Facility Manager for 3 months. Dialysis Program Administration will review results at the conclusion of the audit.	11/04/2015