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
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CERTIFIED MAIL: 7007 3020 0001 4038 9833

November 4, 2014

Zachary Phelps, Administrator
Gate City Dialysis Center
2001 Bench Road
Pocatello, ID 83201-2033

RE: Gate City Dialysis Center, Provider #132506

Dear Mr. Phelps:

Based on the survey completed at Gate City Dialysis Center, on October 23, 2014, by our staff, we have determined Gate City Dialysis Center is out of compliance with the Medicare ESRD Condition for Coverage of **CFC-Patient Plan of Care (42 CFR 494.90)**. 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 this condition to be unmet, substantially limit the capacity of Gate City Dialysis Center, 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 December 7, 2014. 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 November 27, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 17, 2014**.

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.

Sincerely,

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
Kate Mitchell, CMS Region X Office

Gate City Dialysis
2001 Bench Road
Pocatello
83201
Tel: 208-637-0750
www.davita.com

November 13, 2014

Trish O'Hara
Bureau of Facilities Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

Dear Ms. O'Hara:

Please find attached the Plan of Correction for the Statement of Deficiencies identified for Gate City Dialysis Center (Provider #132506). We appreciate the opportunity to remedy the identified deficiencies and feel that we have constructed a plan to remedy the identified items. Please advise us if any additional changes or alterations should be made. We will look forward to your return visit.

Respectfully,

Zach Phelps
Facility Administrator
Gate City Dialysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132506	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATE CITY DIALYSIS CENTER	2001 BENCH ROAD POCATELLO, ID 83201

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 10/20/14 - 10/23/14. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AMA - Against Medical Advice BFR - Blood Flow Rate CVC - Central Venous Catheter EDW - Estimated Dry Weight ICHD - Incenter Hemodialysis kg - kilogram L - Liter mg - milligram min - minute ml - milliliter PCT - Patient Care Technician POC - Plan of Care RN - Registered Nurse RX - prescribed UF - Ultrafiltration (fluid removal) wt - weight	V 000	V000 The Governing Body of Gate City Dialysis has reviewed the Statement of Deficiency from the October 23 2014 CORE Recertification Survey. The Governing Body (GB) has developed and respectfully submits the follow plan of correction. RECEIVED NOV 18 2014 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 and staff interview, it	V 463	V463 On 11/3/14 a full unit meeting which included the IDT members, RD, MSW, RN and PCTs was held by the Facility Administrator (FA) to review and address the conditions and deficiencies identified in the 10/29/14 survey exit interview. On 11/11/14 patient care teammates were retrained on policies: 1-03-09 Intradialytic Treatment Monitoring, 1-03-10 Pre/Post Dialysis Treatment Data Collection, 1-3-08 Treatment Initiation Patient Assessment and 1-03-12 Post Treatment Patient Assessment. Continued on next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Facility Administrator	11/13/14

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 was determined the facility failed to ensure patients' right to receive care as outlined in their POCs was upheld for 4 of 4 ICHD patients (Patients #3 - #6.) This resulted in patients not dialyzing for their prescribed length of time and not running at prescribed blood flow rates. This left patients at risk for complications of inadequate dialysis. Findings include: 1. Prescribed treatment time was not provided to patients as follows: a. Patient #3 was a 64 year old female who had been dialyzing at the facility since 11/11 /13. Her dialysis orders stated she was to receive treatment three times a week for 240 minutes. Thirteen treatment records were reviewed from 9/22/14 - 10/20/14 with the following results: RX Time / Actual Time Date: 9/24/14 — 240 min. — 195 min. 9/29/14 — 240 min. — 231 min. 10/3/14 — 240 min. — 103 min. 10/10/14 — 240 min. — 212 min. Patient #3 did not receive her prescribed treatment time during 4 of 13 treatments reviewed, or 31% of treatments, for a total lost time of 3 hours and 39 minutes. There was no documentation in her record showing Patient #3 was educated as to the risks of missing dialysis time or was offered a time to make up the lost treatment time. b. Patient #5 was a 47 year old male who had been dialyzing at the facility since 4/12/13. His dialysis orders stated he was to receive treatment three times a week for 240 minutes. Ten	V 463	Review of these policies included an emphasis that teammates are required to accurately document treatment events and findings and any needed justification for items that do not match the patient specific plan of care. All clinical teammates will ensure that both BFR and treatment time are per prescription. In the event that BFR cannot be achieved the charge nurse will be notified and a note regarding the actions taken to improve flows & the potential cause will be documented in electronic medical record. Additionally, patient care teammates will add a note in online medical record documentation detailing the problem and any corrective actions taken. Patient Access health will be evaluated by reviewing the Dynamic venous pressure trends. All patients who discontinue treatment early will be asked to sign an AMA form acknowledging the risks of missing dialysis time. Alternate makeup treatment times will be offered at the time of AMA shortened treatment risk reviews. These forms will be discussed with the IDT team during the regularly scheduled Facility Health Meeting (QAPI). Missed treatment time will be tracked and reviewed on a bimonthly basis. Patients who do not meet the prescribed duration of treatment will be offered an additional day of dialysis per physician order. Clinical Coordinator will review access trends and perform post treatment audits on 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months to ensure that all documentation is being done and that results are shared with the IDT team. Patients and Teammates will be provided with the "Know your flow... strive for prescribed" education detailing the potential loss of liters processed by decreased blood flow rates. Continued on next page	

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V 463	Continued From page 2 treatment sheets were reviewed from 9/22/14 - 10/20/14 with the following results: RX Time / Actual Time 9/24/14 240 min. 199 min. 10/6/14 240 min. 185 min. 10/10/14 240 min. 188 min Patient #5 did not receive his prescribed treatment time during 3 of 10 treatments reviewed, or 30% of treatments, for a total lost time of 2 hours and 28 minutes. There was no documentation in his record showing Patient #5 was educated as to the risks of missing dialysis time or was offered a time to make up the lost treatment time. c. Patient #6 was a 60 year old female who had been dialyzing at the facility since 9/3/14. Her dialysis orders stated she was to receive treatment three times a week for 210 minutes. Thirteen treatment sheets were reviewed from 9/22/14 - 10/20/14 with the following results: RX Time / Actual Time 9/26/14 210 min. 121 min. 10/1/14 210 min. 199 min. 10/10/14 210 min. 206 min. 10/17/14 210 min. 0 min. Patient #6 did not receive her prescribed treatment time during 4 of 13 treatments reviewed, or 31% of treatments, for a total lost time of 5 hours and 25 minutes. There was no documentation in her record showing Patient #6 was educated as to the risks of missing dialysis time or was offered a time to make up the lost	V 463	Patient and Teammate education will be on file in the facility records. Missed or shortened treatments and audit results will be reviewed with the Medical Director during monthly FHM (QAPI). Improvement plans will be implemented if necessary by the team. The FA is responsible for this plan of correction.	11/27/14

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treatment time.

In an interview on 10/23/14 at 11:00 A.M., the Facility Administrator stated replacement treatment time should be offered to patients if needed. He stated it was his responsibility to contact the Regional Operations Director and request the facility be opened on non-dialysis days to accommodate patient treatments.

The facility failed to provide prescribed dialysis treatment time to Patients #3, #5, and #6.

2. Prescribed BFR was not provided to patients as follows:

a. Patient #3 was a 64 year old female who had been dialyzing at the facility since 11/11/13. Thirteen treatment records were reviewed from 9/22/14 - 10/20/14. Her dialysis prescription ordered a treatment time of 240 minutes with a BFR of 400 ml/min. Patient #3 did not attain her prescribed BFR during 8 of 13, or 62% of treatments reviewed, leaving her at risk for complications of inadequate dialysis. The following was documented:

Date	RX BFR	Average BFR
9/22/14	400	356
9/24/14	400	240
9/26/14	400	295
9/29/14	400	292
10/1/14	400	262
10/3/14	400	250
10/6/14	400	263
10/8/14	400	152

This was a cumulative 327 liters, or 42%, loss of prescribed blood flow rate during 8 treatments.

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b. Patient #4 was a 59 year old male who had dialyzed at the facility since 2/19/14. Eleven treatment records were reviewed from 9/22/14 - 10/22/14. His dialysis prescription ordered a treatment time of 240 minutes with a BFR of 450 ml/min. Patient #4 did not attain his prescribed BFR during 5 of 11, or 45% of treatments reviewed, leaving him at risk for complications of inadequate dialysis. The following was documented:

Date	RX BFR	Average BFR
9/29/14	450	400
10/3/14	450	425
10/10/14	450	420
10/15/14	450	400
10/22/14	450	425

c. Patient #5 was a 47 year old male who had been dialyzing at the facility since 4/12/13. Eleven treatment records were reviewed from 9/22/14 - 10/20/14. His dialysis prescription ordered a treatment time of 240 minutes with a BFR of 450 ml/min. Patient #5 did not run at his prescribed BFR during 2 of 11, or 18% of treatments reviewed, leaving him at risk for complications of inadequate dialysis. The following was documented:

Date	RX BFR	Average BFR
10/17/14	450	400
10/20/14	450	428

In an interview on 10/23/14 at 11:00 A.M., the facility administrator said it was the responsibility and expectation of each direct care staff member to make sure all elements of the patients' prescriptions were delivered during each

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V 463	Continued From page 5 treatment. The facility failed to provide prescribed blood flow rate to Patients #3 - #5.	V 463		
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on clinical record review, observation, and staff interviews, it was determined the facility failed to implement comprehensive patient POCs for 4 of 4 IHCD patients (Patient #3 - #6) whose records were reviewed. This failure resulted in the risk of inadequate care being provided to patients. 1. Refer to V463 as it relates to the facility's failure to ensure patients' rights to receive care as outlined in their POCs was upheld. 2. Refer to V543 as it relates to the facility's failure to ensure patients' volume status was managed. 3. Refer to V551 as it relates to the facility's failure to ensure a patient's access needs were met.	V 540	V540 Gate City Dialysis takes the Conditions for Coverage very seriously. GB meeting was held on 11/3/14 to review the Condition level deficiencies received under V540 Patient Plan of Care. The specific plans of corrections for this Condition are outlined in each of the following Vtags respectively: V463, V543 and V551. This POC will be reviewed during monthly QAPI meetings and the FA will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes. Members of the GB will meet no less than monthly x 3 months to provide oversight of the QAPI program and to monitor the facility's progress towards the plan of correction compliance. The GB is responsible for this POC.	11/27/14
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 observation, record review and staff	V 543	V543 By 11/27/14, Clinical Teammates will be in serviced by the FA or Charge nurse on the following new processes and responsibilities: On 11/3/14 NP and RN performed a review of all patients' dry weights. Based on average weight gained, average post weight, and input from nursing assessments, new (if needed) dry weights were established for each patient. Medical Director led GB approval obtained 11/10/14 allowing the charge nurse to adjust EDW +/- .5 kg based on patient assessment. A non billable reminder notice will be added to Snappy orders for each patient that the charge nurse is to be notified if any patient does not meet dry weight at the end of each treatment. Continued on next page	

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V 543	Continued From page 6 interview, it was determined the facility failed to ensure POCs were implemented by addressing volume status for 3 of 4 ICHD patients (Patients #3 - #5). This failure resulted in patients not attaining their prescribed dry weight and being put at risk of complications resulting from fluid overload, hypotension, and hypertension. Findings include: 1. Volume status was not adequately managed for each patient as follows: a. Patient #4 was a 59 year old male who had been dialyzing at the facility since 2/19/14. An observation was conducted on 10/22/14 from 8:00 - 11:30 A.M. During that time, Patient #4 came into the facility for treatment. His pre treatment weight was calculated as 90.6 kg by the PCT. His prescribed EDW was 94 kg. The PCT and RN conferred and Patient #4's UF goal was set at 4.0 kg. This would have resulted in his post dialysis weight being 86.6 kg, significantly lower than his prescribed EDW, putting him at risk for low blood pressure. After 40 minutes of treatment, Patient #4's UF rate was turned off (no fluid was being removed) due to his complaint that he felt like he was "going to pass out." His blood pressure at the time was 89/54. The UF rate remained off for the remainder of the treatment and Patient #4's post treatment weight was 93.1 kg. In an interview on 10/22/14 at 10:30 A.M., the nurse said she did not believe Patient #4's pre weight was accurate. She said a 4 kg goal was chosen because "that's what we usually take off of him." She stated Patient #4 did not have on	V 543	By 11/10/14, all clinical teammates will complete the new fluid wise training courses CEC2176A Fluidwise Management Overview, CEC2176B FluidWise Focus Patient Management, CEC2176C FluidWise Facility Performance Management, and CEC2176-POST. This training will implement fluid management care processes for all patients, and fluid status management and interventions for focus patients; ultimately to prevent fluid-related hospitalizations and associated morbidities in dialysis patients. Based on nursing assessment and physician order, patients will be scheduled for additional fluid removal treatments as necessary. Per the recommendation of the Medical Director all weights pre and post treatment will be observed by a teammate of Gate City Dialysis. Additionally, any patient presenting with a weight that seems atypical will be asked to reweigh. RNs were instructed during in servicing that patients returning from a fluid related hospitalization will be assessed and evaluated for any EDW changes that may be needed on first treatment after discharge. RN will notify physician for updated EDW if necessary. Patient education related to fluid management will be provided during all AMA risk reviews. Additional Fluid Management Education is scheduled to be reviewed with all patients during the month of November. Patient education will be documented and filed in the facility education records. The Charge Nurse or FA will audit EDWs in 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months. The audit results will be reviewed in the monthly FHM with the Medical Director. Improvement plans will be implemented if necessary by the team. FA is responsible for this plan of correction.	11/27/14

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the heavy boots that he usually wore, but he was not reweighed in order to determine an accurate pre weight. She stated if Patient #4's pre weight was not accurate, his true dry weight could be determined as his weight when he became hypotensive.

Further, the nurse stated the biomedical technician had told her the scale "hangs up" sometimes and patients needed to be weighed a second time for accuracy when this happened.

The biomedical technician was interviewed on 10/22/14 at 3:00 P.M. He stated he had not been made aware of any scale malfunctions. Documentation showed the scale had been calibrated in May, 2014. He rechecked the scale at the time of the interview and found it to be accurate.

Additionally, Patient #4's records were reviewed prescription included an EDW of 91 kg until 10/3/14 at which time it was increased to 94 kg. Eleven treatment sheets from 9/29/14 - 10/22/14 were reviewed. Patient #4 did not attain his prescribed EDW (+/- 1 kg) for 6 of 11 treatments, 55% of treatments, as follows:

Date	RX EDW	Post wt.
9/29/14	91 kg	97.5 kg
10/1/14	91 kg	96.1 kg
10/3/14	94 kg	96.7 kg
10/6/14	94 kg	98 kg
10/8/14	94 kg	96.6 kg
10/13/14	94 kg	96.3 kg

Further, the facility hospitalization log documented Patient #4 had been hospitalized twice during the preceding 4 months, with a

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diagnosis each time of Hypotension/Shock. His home medication sheet showed he took Midodrine (an antihypotensive drug) 5 mg before each dialysis treatment to support his blood pressure. However, there was no documentation present indicating Patient #4 had been educated as to the risks of fluid overload or offered extra treatment time to remove excess fluid.

In an interview on 10/23/14 at 11:00 A.M., the Facility Administrator confirmed there was no documentation of patient education or offering Patient #4 extra treatment time to remove fluid.

b. Patient #5 was a 47 year old male who had been dialyzing at the facility since 4/12/13. His dialysis prescription included an EDW of 70.5 kg. Eleven treatment sheets were reviewed from 9/22/14 - 10/20/14. Patient #5 did not attain his prescribed EDW (+/- 1 kg) for 10 of 11 of treatments, 91% of treatments, as follows:

Date	RX EDW	Post wt.
9/22/14	70.5 kg	72.9 kg
9/24/14	70.5 kg	72.8 kg
10/1/14	70.5 kg	72.5 kg
10/6/14	70.5 kg	72.5 kg
10/8/14	70.5 kg	72.8 kg
10/10/14	70.5 kg	72.3 kg
10/13/14	70.5 kg	73.8 kg
10/15/14	70.5 kg	72.4 kg
10/17/14	70.5 kg	72.3 kg
10/20/14	70.5 kg	72.2 kg

There was no documentation present indicating Patient #5 had been educated as to the risks of fluid overload or offered extra treatment time to remove excess fluid.

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V 543	Continued From page 9 In an interview on 10/23/14 at 11:00 A.M., the Facility Administrator confirmed there was no documentation of patient education or offering Patient #5 extra treatment time to remove fluid. c. Patient #3 was a 64 year old female who had been dialyzing at the facility since 11/11/13. Her dialysis prescription included an EDW of 105 kg. Thirteen treatment sheets from 9/22/14 - 10/20/14 were reviewed. Patient #3 did not attain her prescribed EDW (+/- 1 kg) for 7 of 13 treatments, 54% of treatments, as follows: Date RX EDW Post wt. 9/24/14 105 kg 106.5 kg 10/3/14 105 kg 106.7 kg 10/6/14 105 kg 107.7 kg 10/8/14 105 kg 106.8 kg 10/13/14 105 kg 107.2 kg 10/15/14 105 kg 107.2 kg 10/20/14 105 kg 107.9 kg There was no documentation present indicating Patient #3 had been educated as to the risks of fluid overload or offered extra treatment time to remove excess fluid. In an interview on 10/23/14 at 11:00 A.M., the Facility Administrator confirmed there was no documentation of patient education or offering Patient #3 extra treatment time to remove fluid. Volume status was not appropriately managed for Patients #3 - #5.	V 543	V551 Procedures 1-04-05 Blood Flow Problems and 1-04-11C Vascular Access Surveillance Dynamic Venous Pressure along with new GB approved process will be reviewed with patient care teammates by 11/27/14. Inservice included a focus on consistently documenting reasons for not meeting prescribed Blood Flow Rates, nurse notification along with nursing interventions. In order to provide optimal care for our patients, GB has approved a PRN referral by the licensed nurse to vascular surgeon for evaluation of CVC's with BFR less than 300 for 3 treatments in a row. The Algorithm for Optimal CVC Function will be used by the charge nurse as a guideline for referral decisions. The referral date and details will be noted in on line medical record documentation by the charge nurse on the date the referral is made. The charge nurse will follow up with the surgeon and obtain visit report for Nephrologist review. Teammates will continue monitoring grafts and fistulas by documenting dynamic venous pressures (DVP) each treatment. The nurse will review DVP trends on a monthly basis and discuss concerns with Nephrologist. To monitor documentation compliance, the FA or charge nurse will audit 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months. The audit results will be reviewed in the monthly FHM with the Medical Director. Improvement plans will be implemented if necessary by the team. FA is responsible for this plan of correction.	11/27/14
V 551	494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored	V 551		

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V 551	Continued From page 10 to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure vascular access failure was identified and addressed for 1 of 1 patients (Patient #3,) who dialyzed using a CVC. This failure resulted in a significant decrease in BFR and dialysis efficiency. Findings include: Patient #3 was a 64 year old female who had been dialyzing at the facility since 11/11/13. She had a history of failed extremity access and was currently dialyzing through a CVC. Her dialysis prescription ordered a BFR of 400 ml/min. for 240 minutes. This would have resulted in 96 L of blood being processed each treatment. Eight treatment records, from 9/22/14 - 10/8/14, were reviewed and showed BFR less than prescribed as follows: - 9/22/14: Average BFR was 356 ml/min. A total of 84 L of blood was processed, 13% less than prescribed. No reason for low BFR was documented. - 9/24/14: Average BFR was 240 ml/min. A total of 41 L of blood was processed, 56% less than prescribed. Nursing documentation stated "tx [treatment] terminated early due to poor arterial flow and low bfr." Treatment time was shortened by 45 minutes due to CVC malfunction. - 9/26/14: Average BFR was 295 ml/min. A total	V 551	V713 During the November 2014 FHM meeting the facility Medical Director reviewed policy 3-03-71 Medical Director Qualifications and Responsibilities. Review focused on the Medical Directors responsibilities in regards to staff education, training, and performance and the Medical Director is responsible for the delivery of patient care and outcomes in the facility. In addition, the Medical Director has approved the plans developed and are outlined below: V463; On 11/3/14 a full unit meeting which included the IDT members, RD, MSW, RN and PCTs was held by the Facility Administrator (FA) to review and address the conditions and deficiencies identified in the 10/29/14 survey exit interview. On 11/11/14 patient care teammates were retrained on policies: 1-03-09 Interdialytic Treatment Monitoring, 1-03-10 Pre/Post Dialysis Treatment Data Collection, 1-3-08 Treatment Initiation Patient Assessment and 1-03-12 Post Treatment Patient Assessment. Review of these policies included an emphasis that teammates are required to accurately document treatment events and findings and any needed justification for items that do not match the patient specific plan of care. All clinical teammates will ensure that both BFR and treatment time are per prescription. In the event that BFR cannot be achieved the charge nurse will be notified and a note regarding the actions taken to improve flows & the potential cause will be documented in electronic medical record. Additionally, patient care teammates will add a note in online medical record documentation detailing the problem and any corrective actions taken. Patient Access health will be evaluated by reviewing the Dynamic venous pressure trends. All patients who discontinue treatment early will be asked to sign an AMA form acknowledging the risks of missing dialysis time. Alternate makeup treatment times will be offered at the time of AMA shortened treatment risk reviews Continued on next page	

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V 551	Continued From page 11 of 69.6 L of blood was processed, 27.5% less than prescribed. No reason for low BFR was documented. - 9/29/14: Average BFR was 292 ml/min. A total of 68.9 L of blood was processed, 28% less than prescribed. A nursing progress note stated "Pt [patient] has a CVC that is difficult to get good flows on." Nine treatment minutes were lost and the dialyzer clotted. -10/1/14: Average BFR was 262 ml/min. A total of 55.8 L of blood was processed, 42% less than prescribed. No reason for low BFR was documented. - 10/3/14: Average BFR was 250 ml/min. A total of 21.2 L of blood was processed, 78% less than prescribed. Treatment time was decreased by 137 minutes. Nursing documentation stated "Arterial pressures will not allow treatment" and "Pt [patient] needs new CVC placement cannot [sic] run even at 200 BFR... Have called Dr. [doctor's name] for new placement appointment office [sic] stated that they will call pt [patient]." - 10/6/14: Average BFR was 263 ml/min. A total of 65.6 L of blood was processed, 32% less than prescribed. No reason for low BFR was documented. -10/8/14: Average BFR was 152 ml/min. A total of 34.3 L of blood was processed, 64% less than prescribed. No nursing documentation was present. - 10/9/14: A new CVC was placed, as evidenced by a surgical consent form signed by Patient #3.	V 551	These forms will be discussed with the IDT team during the regularly scheduled Facility Health Meeting (QAPI). Missed treatment time will be tracked and reviewed on a bimonthly basis. Patients who do not meet the prescribed duration of treatment will be offered an additional day of dialysis per physician order.Clinical Coordinator will review access trends and perform post treatment audits on 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months to ensure that all documentation is being done and that results are shared with the IDT team. Patients and Teammates will be provided with the "Know your flow... strive for prescribed" education detailing the potential loss of liters processed by decreased blood flow rates. Patient and Teammate education will be on file in the facility records. Missed or shortened treatments and audit results will be reviewed with the Medical Director during monthly FHM. Improvement plans will be implemented if necessary by the team. V543; By 11/27/14, Clinical Teammates will be in serviced by the FA or Charge nurse on the following new processes and responsibilities: On 11/3/14 NP and RN performed a review of all patients' dry weights. Based on average weight gained, average post weight, and input from nursing assessments, new (if needed) dry weights were established for each patient. Medical Director led GB approval obtained 11/10/14 allowing the charge nurse to adjust EDW +/- .5 kg based on patient assessment. A non billable reminder notice will be added to Snappy orders for each patient that the charge nurse is to be notified if any patient does not meet dry weight at the end of each treatment. By 11/10/14, all clinical teammates will complete the new fluid wise training courses CEC2176A Fluidwise Management Overview, CEC2176B FluidWise Focus Patient Management, CEC2176C FluidWise Facility Performance Management, and CEC2176- POST. This training will implement fluid management care processes for all patients, and fluid status management and interventions for focus patients; ultimately to prevent fluid-related hospitalizations and associated morbidities in dialysis patients. Continued on next page	

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V 551	Continued From page 12 Seventeen days and 8 treatments elapsed between the time an access showed signs of failure and the time it was corrected. Patient #3 lost 191 minutes of dialysis treatment time and an average of 42.5% dialysis efficiency during this time frame, as a direct result of the failing access. No adequacy studies were performed during this time period to assess the efficiency of Patient #3's dialysis. In an interview on 10/23/14 at 9:00 A.M., the nurse stated that Patient #3's CVC was replaced at the earliest time available, once the vascular surgeon was notified. She did not give a reason as to why the access was not addressed from 9/22/14 until 10/3/14. Patient #3's failing vascular access was not addressed in a timely manner.	V 551	Based on nursing assessment and physician order, patients will be scheduled for additional fluid removal treatments as necessary. Per the recommendation of the Medical Director all weights pre and post treatment will be observed by a teammate of Gate City Dialysis. Additionally, any patient presenting with a weight that seems atypical will be asked to reweigh. RNs were instructed during in servicing that patients returning from a fluid related hospitalization will be assessed and evaluated for any EDW changes that may be needed on first treatment after discharge. RN will notify physician for updated EDW if necessary. Patient education related to fluid management will be provided during all AMA risk reviews. Additional Fluid Management Education is scheduled to be reviewed with all patients during the month of November. Patient education will be documented and filed in the facility education records. The Charge Nurse or FA will audit EDWs in 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months. The audit results will be reviewed in the monthly FHM with the Medical Director. Improvement plans will be implemented if necessary by the team. FA is responsible for this plan of correction. V551; Procedures 1-04-05 Blood Flow Problems and 1-04-11C Vascular Access Surveillance Dynamic Venous Pressure along with new GB approved process will be reviewed with patient care teammates by 11/27/14. Inservice included a focus on consistently documenting reasons for not meeting prescribed Blood Flow Rates , nurse notification along with nursing interventions. In order to provide optimal care for our patients, GB has approved a PRN referral by the licensed nurse to vascular surgeon for evaluation of CVC's with BFR less than 300 for 3 treatments in a row. The Algorithm for Optimal CVC Function will be used by the charge nurse as a guideline for referral decisions. The referral date and details will be noted in on line medical record documentation by the charge nurse on the date the referral is made. The charge nurse will follow up with the surgeon and obtain visit report for Nephrologist review. Teammates will continue monitoring grafts and fistulas by documenting dynamic venous pressures (DVP) each treatment. Continued on next page	
V 713	494.150(b) MD RESP-STAFF ED, TRAINING & PERFORM Medical director responsibilities include, but are not limited to, the following: (b) Staff education, training, and performance. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the Medical Director established adequate monitoring to ensure facility staff demonstrated the competencies necessary to ensure patient needs were met. This failure resulted in delivery of inadequate dialysis treatment and placed all facility patients at risk of complications due to unattained treatment goals. Findings include: 1. Refer to V463 as it relates to the Medical	V 713		

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V 713	Continued From page 13 Director's failure to ensure staff monitored patients for prescribed BFR and prescribed treatment time. 2. Refer to V543 as it relates to the Medical Director's failure to ensure staff managed patients' volume status. 3. Refer to V551 as it relates to the Medical Director's failure to ensure staff addressed a patient's vascular access failure in a timely manner.	V 713	The nurse will review DVP trends on a monthly basis and discuss concerns with Nephrologist. To monitor documentation compliance, the FA or charge nurse will audit 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months. The audit results will be reviewed in the monthly FHM with the Medical Director. Improvement plans will be implemented if necessary by the team. The Clinical Coordinator and back up nurses received training 11/5/14 on Critical Thinking & IDT Relationships and Prevention of complications & Patient Safety practicing with scenarios; Assessing & Monitoring Accesses and documenting access events in Snappy. On 11/19/14 the nurses are scheduled for education on assessing fluid balance and dry weight evaluation; medical emergencies and documentation in Falcon. The Medical Director and FA will be responsible for plan implementation and follow through.	11/27/14
V 714	494.150(c)(1) MD RESP-DEVELOP, REVIEW & APPROVE P&P The medical director must- (1) Participate in the development, periodic review and approval of a "patient care policies and procedures manual" for the facility; This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the Medical Director failed to participate in the development of policies that reflected the facility's current practices related to challenging and attaining patients' EDWs. The failure to develop policies reflecting current standards of practice had the potential to result in inconsistent nursing practice and sub-standard care. The findings include: 1. In an interview on 10/22/14 at 10:00 A.M., the nurse said she had the doctor's approval to challenge any patient's EDW by 5 kg each treatment. She later corrected that value to 0.5 kg each treatment.	V 714	V714 During the November 2014 FHM meeting the facility Medical Director reviewed policy 3-03-71 Medical Director Qualifications and Responsibilities. Review focused on the Medical Directors responsibilities in regards to Staff education, training, and performance and the Medical Director is responsible for the delivery of patient care and outcomes in the facility. In addition, the Medical Director has approved the plans developed and are outlined below: V463; On 11/3/14 a full unit meeting which included the IDT members, RD, MSW, RN and PCTs was held by the Facility Administrator (FA) to review and address the conditions and deficiencies identified in the 10/29/14 survey exit interview. On 11/11/14 patient care teammates were retrained on policies: 1-03-09 Interdialytic Treatment Monitoring, 1-03-10 Pre/Post Dialysis Treatment Data Collection, 1-3-08 Treatment Initiation Patient Assessment and 1-03-12 Post Treatment Patient Assessment.	

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V 714	Continued From page 14 A review of facility policy and procedure showed there was no policy giving staff direction on when or how EDW could be challenged. In an interview on 10/23/14 at 11:00 A.M., the Facility Administrator confirmed there was no written policy for challenging a patient's EDW and said it was just an understanding among staff members. 2. In an interview on 10/22/14 at 10:00 A.M., the nurse said a patient's post treatment dry weight was acceptable if it was within (+/-) 1 kg of the patient's prescribed EDW. In an interview on 10/23/14 at 11:00 A.M., the Clinical Services Specialist said there was a policy stating a patient's post weight was acceptable, and no action was necessary, if it was within (+/-) 1 kg of the patient's prescribed EDW. However, the Facility Administrator was unable to find a policy giving staff direction on acceptable post treatment weights. The facility failed to ensure the Medical Director developed policy and procedure to be used by staff in challenging and attaining patients' EDWs.	V 714	Review of these policies included an emphasis that teammates are required to accurately document treatment events and findings and any needed justification for items that do not match the patient specific plan of care. All clinical teammates will ensure that both BFR and treatment time are per prescription. In the event that BFR cannot be achieved the charge nurse will be notified and a note regarding the actions taken to improve flows & the potential cause will be documented in electronic medical record. Additionally, patient care teammates will add a note in online medical record documentation detailing the problem and any corrective actions taken. Patient Access health will be evaluated by reviewing the Dynamic venous pressure trends. All patients who discontinue treatment early will be asked to sign an AMA form acknowledging the risks of missing dialysis time. Alternate makeup treatment times will be offered at the time of AMA shortened treatment risk reviews. These forms will be discussed with the IDT team during the regularly scheduled Facility Health Meeting (QAPI). Missed treatment time will be tracked and reviewed on a bimonthly basis. Patients who do not meet the prescribed duration of treatment will be offered an additional day of dialysis per physician order. Clinical Coordinator will review access trends and perform post treatment audits on 10% of daily post treatment reports x 3 weeks, then 10% monthly x 2 months to ensure that all documentation is being done and that results are shared with the IDT team. Patients and Teammates will be provided with the "Know your flow... strive for prescribed" education detailing the potential loss of liters processed by decreased blood flow rates. Patient and Teammate education will be on file in the facility records. Missed or shortened treatments and audit results will be reviewed with the Medical Director during monthly FHM (QAPI). Improvement plans will be implemented if necessary by the team. The Medical Director and FA are responsible for this plan of correction.	11/27/14