IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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November 12, 2014

Jordana Ratel, Administrator
Fresenius Medical Center Hayden Lake
7600 Mineral Drive, Suite 850
Coeur D Alene, ID 83815

RE: Fresenius Medical Center Hayden Lake, Provider #132525

Dear Ms. Ratel:

This is to advise you of the findings of the Medicare survey of Fresenius Medical Center Hayden Lake, which was conducted on November 6, 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 **November 23, 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
	132525	A. BUILDING _____ B. WING _____	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CENTER HAYDEN LAKE	7600 MINERAL DRIVE, SUITE 850 COEUR D ALENE, ID 83815

(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 11/3/14 - 11/6/14. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: AVF - Arteriovenous fistula EDW - Estimated dry weight HHD - Home Hemodialysis HT - Home Therapies ICHD - In Center Hemodialysis kg - kilogram POC - Plan of Care RX - Prescribed wt - weight	V 000		
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 a POC was implemented by addressing volume status for 1 of 2 ICHD patients (Patient #1) whose records were reviewed. This failure resulted in the patient not attaining his prescribed dry weight and being put at risk of complications resulting from fluid overload, respiratory distress, and possible hospitalization. Findings include:	V 543		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 543	Continued From page 1 Patient #1's medical record documented a 66 year old male who had been admitted to the facility on 5/14/14. He was hospitalized from 10/1/14 - 10/5/14 after being transported from the dialysis unit, via ambulance, to the hospital. His hospital discharge diagnoses included fluid overload, acute pulmonary edema, and acute respiratory failure. Patient #1's prescribed EDW was 102 kg. Five treatment records, from 10/6/14 - 10/15/14 were reviewed. Volume status was not adequately managed for Patient #1 during 4 of 5, or 80%, of treatments as follows: Date RX EDW Post wt. 10/06/14 102 kg 103.2 kg 10/10/14 102 kg 103.2 kg 10/13/14 102 kg 103.8 kg 10/15/14 102 kg 103.3 kg Patient #1 was hospitalized again from 10/17/14 - 10/20/14 for pneumonia. In an interview on 11/5/14 at 10:00 A.M., the Clinical Manager said if a patient's post weight was +/- 2 kg of the prescribed EDW an Adverse Event form would be completed per facility policy. She stated it would be a nursing judgement whether to take action if a patient's post weight was less than +/- 2 kg of the prescribed EDW. During the same interview the Clinical Manager reviewed the treatment sheets and confirmed Patient #1 had not attained his prescribed EDW. Volume status was not managed for a patient.	V 543		
V 764	494.180(d) GOV-SERVICES FURNISHED ON	V 764		

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V 764	Continued From page 2 THE MAIN PREMISES The governing body is responsible for ensuring that the dialysis facility furnishes services directly on its main premises or on other premises that are contiguous with the main premises and are under the direction of the same professional staff and governing body as the main premises (except for services provided under §494.100). This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the governing body failed to ensure home hemodialysis training was provided at the facility. This failure directly impacted 1 of 1 patients (Patient #3) who was admitted to the HHD program during the 90 days prior to survey. This failure caused unwarranted time and travel by the patient in order to acquire training. Findings include: Patient #3's medical record documented a 48 year old male with a diagnosis of hereditary polycystic kidney disease. He was on the active transplant list and had a functioning AVF. He had chosen HHD in an effort to continue full time employment. Dialysis became necessary for Patient #3 in July, 2014. The facility was unable to provide HHD training and Patient #3 was sent to another corporate facility in an adjoining state, approximately 36 miles away. When his training was completed, Patient #3 returned to the facility and was admitted to the HHD program for support and monitoring. In an interview on 11/4/14 at 1:30 P.M., the Clinical Manager said the facility's HT program served patients in the local and surrounding	V 764		

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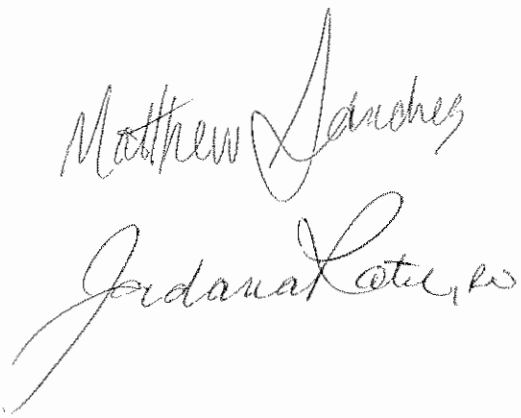
V 764	Continued From page 3 areas including the town in which Patient #3 lived, 7 miles away. In an interview on 11/4/14 at 5:10 P.M., the Director of Operations-Home Therapies was asked why HHD training was not provided to Patient #3 at the facility. He said the facility's HT nurse had vacated her position in July, 2014 and was not replaced until 8/31/14. Her replacement did not have HHD experience. The Program Manager was training the replacement nurse, as well as providing support to current HHD patients, and would not have been able to provide Patient #3 with HHD training until October, 2014. When asked why staff was not sent to the facility from other units, the Director said staff members were occupied training patients at other facilities. HHD training was not provided to a patient in his certified facility.	V 764		

Plan of Correction:

Standard Citation V 543:

1. The Clinical Manager held a meeting on 11/21/14 with DPC staff to review and re-educate on the following policies: FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy and FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy.
2. All patients will be referred to the charge nurse/Team Leader (RN) for any post treatment weight with a variance from the estimated dry weight of .5 kg or no change in weight from a patient's last treatment post weight.
3. In addition the Clinical Manager or her designee will perform weekly treatment sheet audits for 4 weeks starting 11/24/14.The Clinical Manager will monitor the progress of staff documentation and assess that volume status of the patients is being adequately managed.
4. The education department has been scheduled to provide additional education on 11/21/14. Education will be focused on calculating UF goals and documentation of appropriate interventions in response to changes in vital signs, treatment parameters, or machine adjustments. Documentation of monitoring will be completed on the treatment record.
5. Audit results will be reviewed and presented to the QAI team beginning December QAI meeting. The QAI committee will provide oversight to the development or revision of the plan of action being taken and ensure resolution is occurring and sustained.
6. The Clinical Manager will be responsible to review, analyze and trend results and present to QAI committee for review and oversight.
7. The Governing Body is responsible to review and analyze all data including monitoring results for issues and trends. Based on the audit results the Governing Body will make determination as to the frequency of the audits moving forward.



The Governing Board of this facility whose membership includes the Medical Director, Clinical Manager, Area Manager, and Regional Vice President will oversee the clinics ability to furnish the services that it is approved to provide. The Governing Body will take these necessary steps to ensure that HHD training will occur:

V764

1. Home Therapy Manager will start training RN on Home Hemodialysis December 29, 2014 and complete training March 30, 2015.
2. The Home Therapy Program Manager is responsible for patient training if at any time the facility does not have a Home Dialysis RN who is competent to provide training for HHD.
3. If during this time frame the Home Therapy Manager is unable to train a new patient, arrangements will be made to bring in a HHD nurse from another FMC clinic.
4. The Home Therapy Manager will be responsible for presenting the progress of the HHD training to the QAI committee monthly for review and oversight.
5. The Governing Body is responsible for reviewing the progress of the Home Hemodialysis training. The Governing Body is responsible for ensuring the nurse has the competency and skills necessary to provide safe HHD services.

Matthew Sanchez

Jordana Cotie, RN