IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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June 30, 2016

Evelyn Considine, Administrator
North Idaho Dialysis Unit
2100 Ironwood Court
Coeur d'Alene, ID 83814

RE: North Idaho Dialysis Unit, Provider #132507

Dear Ms. Considine:

This is to advise you of the findings of the Medicare survey of North Idaho Dialysis Unit, which was conducted on June 23, 2016.

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 13, 2016,** and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

Trish O'Hara

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

Dennis Kelly
on behalf of

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
	132507	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IDAHO DIALYSIS UNIT	2100 IRONWOOD COURT COEUR D'ALENE, ID 83814

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 6/20/16 - 6/23/16. The surveyor conducting the survey were: Trish O'Hara RN, HFS Acronyms used in this report include: Anti-HBs - Antibody to Hepatitis B surface antigen HBsAG - Hepatitis B surface antigen IV - Intravenous kg- kilogram (2.2 pounds) mIU - milli International Unit ml - milliliter PCT - Patient Care Technician POC - Plan of Care UF - Ultrafiltration (fluid removal)	V 000		
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used	V 116	RECEIVED JUL 13 2016 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evelyn Considine — TITLE: Clinic Manager, RN — (X6) DATE: 7/7/2016

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 116	Continued From page 1 on other patients. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure supplies were dedicated for use on a single patient. This failure directly impacted 1 of 3 patients (Patient #7) observed completing treatment, and had the potential to impact all patients dialyzing at the facility. The findings include: During an observation on 6/21/16 from 9:00 AM - 11:15 AM, the first PCT was discontinuing dialysis treatment for Patient #7 who was seated in treatment station #5. The PCT needed extra gauze squares to control bleeding at the patient's needle sites. She called out to team members to assist her by bringing extra gauze to Patient #7's treatment station. A second PCT was working with a patient seated in treatment station #2. The second PCT removed gauze from the tray table in treatment station #2 and took it to treatment station #5 where it was used to dress Patient #7's needle sites. In an interview at the time of observation, the second PCT said she was not aware she was cross contaminating by transferring gauze from one treatment station to another. She said she was in her orientation period and was "learning all the time." The first PCT was tending to Patient #7's bleeding issues and was not aware the gauze had come from another treatment station. The facility failed to ensure supplies were used for only one patient.	V 116		
V 124	494.30(a)(1)(i) IC: HBV: TEST ALL,REV	V 124		6/22/16

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V 124	Continued From page 2 RESULTS/STATUS B4 ADMIT Routine Testing for Hepatitis B The HBV serological status (i.e. HBsAg, total anti-HBc and anti-HBs) of all patients should be known before admission to the hemodialysis unit. Routinely test all patients [as required by the referenced schedule for routine testing for Hepatitis B Virus]. Promptly review results, and ensure that patients are managed appropriately based on their testing results. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to provide infection control precautions for 1 of 7 patients (Patient #3) whose Hepatitis status was reviewed. This failure placed patients at risk of complications caused by undetected Hepatitis B infections. The findings included: According to the CDC "Recommendations for Preventing transmission of Infections Among Chronic Hemodialysis Patients" (MMWR, Vol. 50/No. RR-5), anti-HBs is a serological test to determine a person's immunity to the Hepatitis B virus. A laboratory value less than 10 mIU/ml indicates no immunity to the virus. A value more than 10 mIU/ml indicates the person has immunity to the Hepatitis B virus. The document defined HBsAg as a serological test to determine the presence of active Hepatitis B virus. A negative result would indicate no active disease. A positive result would indicate active Hepatitis B virus. A facility policy titled Patient Testing and	V 124		

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V 124	Continued From page 3 Vaccination for Hepatitis B, dated 8/20/14, stated all patients who were susceptible to Hepatitis B (having an anti-HBs less than 10 mIU/ml) should be tested for active disease each month by having an HBsAg value drawn. The policy also stated "the Hepatitis B vaccine shall be offered to all susceptible patients..." Patient #3 was a 75 year old male who was admitted to the facility on 3/11/16. A Hepatitis Summary Report, dated 5/19/16, showed Patient #3 was susceptible to Hepatitis B, having an anti-HBs value of less than 10 mIU/ml on 3/11/16. However, no HBsAg, indicating active disease, was drawn for three months, until 6/6/16. Further, no documentation was present indicating Patient #3 had been offered the Hepatitis B vaccine series. In an interview on 6/22/16 at 9:00 a.m., the Clinical Manager reviewed the Hepatitis Summary Report and Patient #3's record. She confirmed the missing lab testing and offer of vaccine to the patient. The facility failed to ensure Patient #3's Hepatitis B status was monitored, and failed to offer him the protective vaccine.	V 124		
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	V 543		6/27/16

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V 543	Continued From page 4 was determined the facility failed to ensure a POC was implemented by addressing volume status for 6 of 6 patients (Patients #1 - #6) whose records were reviewed. This failure resulted in patients being put at risk of complications resulting from fluid overload. The findings included: Dialysis treatment sheets documented the patient's pre dialysis weight, the amount of fluid removed during treatment (UF), and the patient's post dialysis weight. There also were areas on the sheet for staff to document any oral fluids the patient ingested during treatment and any IV fluid given to the patient by staff during treatment. Discrepancies in the expected post weight for patients were as follows: a. Patient #4 was a 67 year old female who was admitted to the facility on 6/7/12. Twelve treatment sheets, from 5/21 - 6/18/16, were reviewed with the following results: - 5/21/16: Pre weight 142.8 kg - 5.4 kg UF = 137.4 kg expected post weight. Actual post weight was 138.3 kg, 0.9 kg more than expected. - 5/26/16: Pre weight 139.8 kg - 4.0 kg UF = 135.8 kg expected post weight. Actual post weight was 136.8 kg, 1.0 kg more than expected. - 6/2/16: Pre weight 141.8 kg - 5.3 kg UF = 136.5 kg expected post weight. Actual post weight was 137.4 kg, 0.9 kg more than expected. - 6/4/16: Pre weight 140.9 kg - 2.3 kg UF = 138.6 kg expected post weight. Actual post weight was 139.9 kg, 1.3 kg more than expected.	V 543		

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V 543	Continued From page 5 - 6/7/16: Pre weight 134.4 kg - 2.9 kg UF = 131.5 kg expected post weight. Actual post weight was 138.8, 7.3 kg more than expected and 4.4 kg more than pre dialysis weight. - 6/11/16: Pre weight 135 kg - 3.0 kg UF = 132 kg expected post weight. Actual post weight was 133 kg, 1.0 kg more than expected. - 6/16/16: Pre weight 136 kg - 4.0 kg UF = 132 kg. Actual post weight was 133.1 kg, 1.1 kg more than expected. - 6/18/16: Pre weight 136.3 kg - 5.0 kg UF = 131.3 kg expected post weight. Actual post weight was 132.1, 0.8 kg more than expected. No oral or IV fluids were documented as having been given during these treatments. b. Patient #2 was a 78 year old female who was admitted to the facility on 3/23/13. Nine treatment sheets, from 5/21 - 6/9/16, were reviewed with the following results: - 5/24/16: Pre weight 132.6 kg - 2.3 kg UF = 130.3 kg expected post weight. Actual post weight was 127.4 kg, 2.9 kg less than expected. - 5/28/16: Pre weight 133.9 kg - 4.0 kg UF = 129.9 kg expected post weight. Actual post weight was 127.3 kg, 2.6 kg less than expected. - 5/31/16: Pre weight 131.5 kg - 3.8 kg UF = 127.7 kg expected post weight. Actual post weight was 128.4 kg, 0.7 kg more than expected. - 6/2/16: Pre weight 129.5 kg - 2.6 kg UF = 126.9 kg expected post weight. Actual post weight was	V 543		

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V 543	Continued From page 6 127.7 kg, 0.8 kg more than expected. - 6/4/16: Pre weight 130.4 kg - 3.0 kg UF = 127.4 kg expected post weight. Actual post weight was 128.1 kg, 0.7 kg more than expected. - 6/7/16: Pre weight 129.5 kg - 2.6 kg UF = 126.9 kg expected post weight. Actual post weight was 128.2 kg, 1.3 kg more than expected. No oral or IV fluids were documented as having been given during these treatments. c. Patient #6 was a 56 year old male who was admitted to the facility on 10/29/14. Twelve treatment sheets, from 5/23 - 6/20/16, were reviewed with the following results: - 5/23/16: Pre weight 135.9 kg - 3.8 kg UF = 132.1 kg expected post weight. Actual post weight was 132.8 kg, 0.7 kg more than expected. - 5/25/16: Pre weight 134.8 kg - 3.8 kg UF = 131 kg expected post weight. Actual post weight was 132 kg, 1.0 kg more than expected. - 5/30/16: Pre weight 134.8 kg - 4.0 kg UF = 130.8 kg expected post weight. Actual post weight was 131.6 kg, 0.8 kg more than expected. - 6/3/16: Pre weight 132.9 kg - 2.7 kg UF = 130.2 kg expected post weight. Actual post weight was 131.4 kg, 1.2 kg more than expected. No oral or IV fluids were documented as having been given during these treatments. d. Patient #5 was a 54 year old male who was admitted to the facility on 10/25/15. Eleven	V 543		

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V 543	Continued From page 7 treatment sheets from, 5/21 - 6/18/16, were reviewed with the following results: - 5/24/16: Pre weight 75.3 kg - 3.5 kg UF = 71.8 kg post weight. Actual post weight was 73 kg, 1.2 kg more than expected. - 6/11/16: Pre weight 77.8 kg - 3.7 kg UF = 74.1 kg expected post weight. Actual post weight was 75.2 kg, 1.1 kg more than expected. - 6/14/16: Pre weight 77.6 kg - 5.0 kg UF = 72.6 kg expected post weight. Actual post weight was 73.3 kg, 0.7 kg more than expected. - 6/18/16: Pre weight 76.2 kg - 3.4 kg UF = 72.8 kg post weight. Actual post weight was 73.7, 0.9 kg more than expected. No oral or IV fluids were documented as having been given during these treatments. e. Patient #3 was a 75 year old male who was admitted to the facility on 3/11/16. Thirteen treatment sheets, from 5/23 - 6/17/16, were reviewed with the following results: - 5/27/16: Pre weight 105.2 kg - 1.1 kg UF = 104.1 kg expected post weight. Actual post weight was 104.1 kg, 1.0 kg more than expected. - 6/1/16: Pre weight 105.5 kg - 1.5 kg UF = 104 kg expected post weight. Actual post weight was 107.9 kg, 3.9 kg more than expected and 2.4 kg more than the patient's pre dialysis weight. No oral or IV fluids were documented as having been given during these treatments.	V 543		

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V 543	Continued From page 8 f. Patient #1 was a 66 year old male who was admitted to the facility on 4/22/16. Eleven treatment sheets, from 5/25 - 6/13/16, were reviewed with the following results: - 5/25/16: Pre weight 88.2 kg - 1.3 kg UF = 86.9 kg expected post weight. Actual post weight was 88.5 kg, 1.6 kg more than expected and 0.3 kg more than the patient's pre treatment weight. No oral or IV fluids were documented as having been given during these treatments. In an interview on 6/22/16 at 9:00 a.m., the Clinical Manager confirmed the post weight discrepancies. She said any oral or IV fluids should have been included in the documentation if given. The facility failed to ensure fluid was managed for six patients.	V 543		

Fresenius Medical Care

Dba North Idaho Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: June 23, 2016

V 116

On June 24, 2016, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- **Dialysis Precautions Policy**

Emphasis was placed on:

- Non disposable items that cannot be cleaned and disinfected (e.g., gauze) should be designated for single use only. Unused supplies taken to patient station should not be returned to common clear area or used on other patients.

Effective July 14, 2016, Clinical Manager or Charge Nurse will conduct weekly audits utilizing Cleaning and Disinfection of the Dialysis Station, Initiation of Dialysis with a Central Venous Catheter, Discontinuation of Dialysis with a Central Venous Catheter, Initiation of Dialysis with an AVF or AVG, Discontinuation of Dialysis with an AVF or AVG for 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Infection Control Audit per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on **June 23, 2016.**

V 124

On June 24, 2016, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- **Patient Testing and Vaccination for Hepatitis B Policy**

Emphasis was placed on:

- Patients who are susceptible to Hepatitis B will be tested for antigens each month.
- The Hepatitis B vaccine shall be offered to all susceptible patients

Effective Immediately, Clinical Manager or designee will run Hepatitis Summary Report and obtain consents to vaccinate susceptible patients with no contraindications to the vaccine.

Effective July 14, 2016 Clinical Manager or Charge Nurse will conduct monthly audits utilizing Hepatitis Summary Report. Monitoring will be done through the Patient Testing and Vaccination for Hepatitis B using the Hepatitis Report monthly per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on **June 22, 2016.**

V 543

On June 24, 2016, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies:

- **Patient Evaluation Pre Treatment Policy**
- **Patient Evaluation Post Treatment Policy**
- **Nursing Supervision and Delegation Policy**

Emphasis was placed on:

- Pre Treatment, the staff member who collects the weight information and evaluates the patient pre-treatment will document their findings in the hemodialysis treatment record. If the PCT/LPN notes any changes or abnormal findings in the patient's condition or vascular access are observed or reported by the patient, or the patient was hospitalized, the abnormal finding confirmed by the RN will be reported to the attending physician for assessment and intervention
- Weigh the patient and compare to pre-treatment weight. Note: If the patient is unstable and no measurement of weight available, consider other methods of blood volume monitoring as ordered by the attending physician
- Ensure the patient zeros the scale first prior to taking his/her weight
- Patient scale was calibrated on 07/07/2016 to verify weights are accurate
- Obtain the last hemodialysis flowsheet from Acute Dialysis every time a patient gets hospitalized as communication sheet for patient's new EDW

Effective July 14, 2016, Clinical Manager or Charge Nurse will conduct weekly audits utilizing Patient Pre-hemodialysis Treatment Audit and Patient Post-treatment Audit for 4 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Accuracy of Treatment Outcome per QAI calendar.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.

The Clinical Manger is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The deficiency was corrected on **June 27, 2016.**