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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September 26, 2016

Phyllicia Harris, Administrator
Liberty Dialysis Idaho Falls
2381 East Sunnyside Road
Idaho Falls, ID 83404

RE: Liberty Dialysis Idaho Falls, Provider #132514

Dear Ms. Harris:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Idaho Falls, which was conducted on September 16, 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 **October 9, 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,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132514	A. BUILDING _____ B. WING _____	09/16/2016

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LIBERTY DIALYSIS IDAHO FALLS	2381 EAST SUNNYSIDE ROAD IDAHO FALLS, ID 83404

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 9/12/16 - 9/16/16. The surveyor conducting the survey was: Trish O'Hara RN, HFS Acronyms used in this report include: AVF - Arteriovenous Fistula AVG - Atreiovenous Graft CVC - Central Venous Catheter ICHD - Incenter Hemodialysis ml - milliliter POC - Plan Of Care UF - Ultrafiltration (fluid removal)	V 000	RECEIVED OCT - 5 2016 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, observations, policy review, and staff interview, it was determined the facility failed to ensure patients' right to receive care as outlined in their POCs was upheld for 8 of 8 ICHD patients (Patients #1 - 8) whose records were reviewed or whose blood draw was observed. This resulted in the potential for negative patient outcomes due to inadequate monitoring, incorrect Heparin dose	V 463	Plan of Correction Action Plan On October 11, 2016, the Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on the following policies: 1. FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy 2. FMS-CS-IC-II-135-016C Drawing Blood Work Pre Treatment using an AVF/AVG or Catheter Emphasis was placed on the requirements to ensure staff practice: 1. Staff will monitor patient vital signs at the initiation of dialysis and every 30	Completion Oct 25,2016

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

Phyllisha Hamsen RN — Clinic Manager — 10-3-2016

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 463	Continued From page 1 administration, and incorrect blood draw technique. The findings include: A policy titled Patient Monitoring During Patient Treatment, revised 11/20/14, stated "Vital signs will be monitored at the initiation of dialysis and every 30 minutes..." 1. Six of seven patients (Patients #1 - #6) whose treatment records were reviewed, did not receive vital sign monitoring every 30 minutes, as follows: a. Patient #1 was a 59 year old male. Eleven treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments, as follows: - On 8/19/16 from the start of treatment at 3:10 p.m. until 4:30 p.m. - On 8/29/16 from 3:31 p.m. until 4:31 p.m., and again from 4:31 p.m. until 5:33 p.m. - On 8/31/16 from 3:33 p.m. until 4:39 p.m. - On 9/5/16 from 4:09 p.m. until 5:09 p.m. - On 9/7/16 from 6:02 p.m. until the end of treatment at 7:28 p.m. - On 9/12/16 from the start of treatment at 3:06 p.m. until 4:02 p.m. b. Patient #2 was a 50 year old male. Twelve treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments as follows: - On 8/17/16 from 3:03 p.m. until 4:33 p.m. - On 8/19/16 from 3:44 p.m. until the end of treatment at 4:53 p.m. - On 8/31/16 from 1:38 p.m. until 2:37 p.m. - On 9/2/16 from 3:02 p.m. until 4:07 p.m. - On 9/12/16 from 1:34 p.m. until 2:42 p.m., and	V 463	minutes, or more frequently, as needed per policy. 2. Staff will appropriately collect all blood specimens following Fresenius Policy and Procedure to ensure consistency and accuracy of the results. 3. Staff will ensure that patients receive the Heparin as prescribed. Staff will be educated on proper documentation of Heparin administration. By October 21, 2016, all Direct Patient Care staff members will have given a return demonstration to the Clinical manager or designee of appropriately collecting blood specimens. Effective on October 3, 2016, the Clinical Manager or designee will conduct 5% of patient treatment sheets weekly focusing on vital signs every 30 minutes and heparin administered using the Flowsheet audit tool. The QAI committee will determine on-going frequency of the audits based on compliance. Once compliance, sustained monitoring will be done through the Medical Record Audit per QAI calendar.	

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V 463	Continued From page 2 again from 3:01 p.m. until 4:01 p.m. c. Patient #3 was a 66 year old male. Twelve treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments, as follows: - On 8/19/16 from 9:41 a.m. until the end of treatment at 10:39 a.m. - On 8/22/16 from 9:07 a.m. until the end of treatment at 10:34 a.m. - On 8/26/16 from 7:30 a.m. until 8:38 a.m., and again from 9:30 a.m. until the end of treatment at 10:32 a.m. d. Patient #4 was a 63 year old male. Twelve treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments, as follows: - On 8/24/16 from 3:06 p.m. until 4:01 p.m. - On 8/27/16 from the start of treatment at 3:30 p.m. until 4:30 p.m. - On 8/31/16 from 4:02 p.m. until 5:03 p.m. - On 9/3/16 from 1:36 p.m. until 2:34 p.m., and again from 2:34 p.m. until 3:32 p.m. - On 9/10/16 from 5:31 p.m. until the end of treatment at 6:24 p.m. - On 9/12/16 from 4:03 p.m. until 5:09 p.m. e. Patient #5 was a 27 year old female. Thirteen treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments, as follows: - On 8/22/16 from 3:33 p.m. until 4:30 p.m. - On 8/24/16 from 3:04 p.m. until 3:57 p.m. - On 8/27/16 from the start of treatment at 3:44 p.m. until 4:41 p.m.	V 463	Any ongoing non-compliance by staff, per the Conditions for Coverage and the FMC policy, will be addressed with corrective action as appropriate. 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 ensure all documentation required to ensure the resolution of the deficiencies is provided to the QAI Committee on a monthly basis. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.	

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- On 9/5/16 at 4:35 p.m. Patient #5's blood pressure was 109/79. The nurse noted the UF would be decreased and blood pressure would be rechecked every 15 minutes. Blood pressure was not checked for 35 minutes (at 5:10 p.m.) at which time it had decreased to 88/64.
- On 9/7/16 from 3:43 p.m. until 4:38 p.m.
- On 9/9/16 from 3:00 p.m. until 4:05 p.m. During this time Patient #5's blood pressure had dropped from 170/115 to 110/71.

f. Patient #6 was a 23 year old female. Twelve treatment records were reviewed from 8/17/16 - 9/12/16. Vital sign monitoring was not documented during treatments as follows:

- On 8/17/16 from 7:01 a.m. until 8:31 a.m.
- On 8/19/16 from 6;46 a.m. until 7:31 a.m.
- On 8/31/16 from 6:32 a.m. until 7:32 a.m.

In an interview on 9/15/16 at 12:30 p.m., the Administrator confirmed the missed monitoring for Patients #1 - #6, and provided the policy stating vital sign monitoring was to be done every 30 minutes.

The facility failed to monitor patients according to policy.

2. On 9/15/16 at 11:45 a.m. the following was observed during Patient #8's blood draw:

Staff was preparing to initiate dialysis for Patient #8, accessing her CVC. Staff removed the Heparin dwell from both catheter limbs. Staff then flushed the limbs with saline and administered a Heparin bolus. Staff then withdrew 20 ml of blood from one limb, attached a Vacutainer, and drew 2 tubes of blood for

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V 463	Continued From page 4 laboratory testing. Staff attached identifying labels to the tubes of blood and proceeded to initiate Patient #8's dialysis treatment. When asked at the time of the observation, staff said she had forgotten to draw the blood samples prior to flushing the catheter limbs. Staff said she thought if she removed 20 ml of blood from the catheter limb it would clear any saline and Heparin and provide an appropriate blood sample. Staff said she would tell the nurse about the incorrect procedure in case Patient #8's laboratory results returned questionable values. A policy titled Drawing Blood Work Pre-Treatment from an AVF/AVG or Catheter, revised 1/4/12, stated "Withdraw and discard 5 ml of blood from each catheter lumen prior to obtaining blood tube specimens. Heparin per physician order should then be administered after all lab specimen tubes have successfully filled. All blood specimens will be obtained following the same processes to ensure consistency and accuracy of results." In an interview on 9/15/16 at 12:45 p.m., the Administrator confirmed the blood draw was not done appropriately, leaving Patient #8 at risk of treatment or medication changes based on incorrect laboratory results from tainted blood samples. The facility failed to provide Patient #8 with accurate blood sampling. 3. Six of seven patients (Patients #1, #2, and #4 - #7) whose records were reviewed, did not receive prescribed Heparin doses, as follows: a. Patient #1 was a 59 year old male who used a	V 463		

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V 463	Continued From page 5 CVC to dialyze. His treatment sheets showed Heparin 500 units/hour was ordered for the length of his 4.25 hour treatment (a total of 2125 units). This was documented as infusion Heparin. Patient #1's treatment sheets documented the following total infused Heparin doses: 8/19/16 - 4000 units 9/7/16 - 1600 units 9/12/16 - 3100 units b. Patient #2 was a 50 year old male who used a right arm AVF to dialyze. His treatment sheets showed Heparin 2000 units/hour was ordered for 4.5 hours of his 4.75 hour treatment (a total of 9000 units). This was documented as infusion Heparin. Patient #2's treatment sheets documented the following total infused Heparin doses: 8/17/16 - 7400 units 8/19/16 - 7400 units 8/22/16 - 7500 units 8/24/16 - 7500 units 8/26/16 - 7500 units 8/29/16 - 7500 units 8/31/16 - 6900 units 9/2/16 - 7500 units 9/5/16 - 7500 units 9/7/16 - 7400 units 9/9/16 - 7500 units 9/12/16 - 11,500 units c. Patient #4 was a 53 year old male who used a CVC to dialyze. His treatment sheets showed Heparin 1000 units/hour was ordered for the length of his 3.75 hour treatment (a total of 3750 units). This was documented as infusion Heparin. Patient #4's treatment sheets	V 463		

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V 463	Continued From page 6 documented the following total infused Heparin doses: 8/27/16 - 2700 units 9/5/16 - 3900 units 9/7/16 - 4700 units 9/10/16 - 9500 units d. Patient #5 was a 27 year old female who used a CVC to dialyze. Her treatment sheets showed Heparin 500 units/hour was ordered for the length of her 3.5 hour treatment (a total of 1750 units). This was documented as infusion Heparin. Patient #5's treatment sheets documented the following total infused Heparin doses: 8/19/16 - 2200 units 8/26/16 - 2400 units (during a 1 hour treatment) 8/27/16 - (1800 units during a 2.75 hour treatment) 8/31/16 - 1200 units 9/12/16 - 2700 units e. Patient #6 was a 23 year old female who used a left arm AVF to dialyze. Her treatment sheets showed Heparin 500 units/hour was ordered for the length of her 3.25 hour treatment (a total of 1625 units). This was documented as infusion Heparin. Patient #6's treatment sheets documented the following total infused Heparin doses: 8/17/16 - 1100 units 8/19/16 - 1100 units 8/22/16 - 1100 units 8/24/16 - 1000 units 8/26/16 - 1100 units 8/29/16 - 1100 units 8/31/16 - 1100 units	V 463		

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V 463	Continued From page 7 9/2/16 - 1100 units 9/5/16 - 1100 units 9/7/16 - 1100 units 9/9/16 - 1100 units 9/12/16 - 2100 units f. Patient #7 was a 44 year old female who used a CVC to dialyze. Her treatment sheets showed Heparin 500 units/hour was ordered for the length of her 3.5 hour treatment (a total of 1750 units). This was documented as infusion Heparin. Patient #7's treatment sheets documented the following total infused Heparin doses: 8/26/16 - 2700 units 8/29/16 - 2700 units 8/31/16 - 2800 units 9/7/16 - 2700 units In an interview on 9/15/16 at 12:45 p.m., the Administrator confirmed the documented Heparin doses for Patients #1, #2, and #4 - #7. She said the doses were manually entered into the treatment sheets after staff visually inspected the contents of the Heparin pump syringe at the end of treatment. She said she would have to look at each treatment sheet to determine why the doses documented did not match the prescribed doses. The facility failed to administer Heparin as prescribed.	V 463		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier	V 726	On October 11, 2016, the Clinical Manager will hold a Direct Patient Care staff meeting and reinforce the expectations and responsibilities of the staff on the following: 1. Maintaining complete and accurate records on all patients. 2. Facility protocol for Heparin Emphasis was placed on the requirements to ensure staff practice: 1. Staff will ensure that patients receive Heparin as prescribed.	Oct 25,2016

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V 726	Continued From page 8 that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to maintain accurate treatment records for 2 of 7 ICHD patients (Patients #2 and #6) whose treatment records were reviewed. Incorrect information on patients' treatment sheets created the potential for patients being put at risk of excessive bleeding due to incorrect Heparin doses being administered during treatments. The findings include: 1. Patient #2 was a 50 year old male who used a right arm AVF to dialyze. Twelve treatment sheets, from 8/17/16 - 9/12/16, ordered his infusion Heparin to be stopped 15 minutes before the end of his treatment. However, 12 of the 12 treatment sheets reviewed documented Heparin doses indicating Heparin infusion had been stopped 60 minutes before the end of treatments. 2. Patient #6 was a 23 year old female who used a left arm AVF to dialyze. Twelve treatment sheets, from 8/17/16 - 9/12/16, ordered her infusion Heparin to be stopped 0 minutes before the end of her treatment. However, 12 of the 12 treatment sheets reviewed documented Heparin doses indicating Heparin infusion had been stopped 60 minutes before the end of treatments. In an interview on 9/15/16 at 12:45 p.m., the Administrator said the facility protocol was for Heparin infusion to be stopped 60 minutes before the end of treatment for patients who used an AVF or AVG for dialysis and Heparin infusion to continue to the end of treatment for patients who	V 726	2. Staff accurately document Heparin administration in the medical record. On September 19 and 20, 2016, the Clinic Manager performed medical record audit on all In-center patient's Heparin orders. All orders were reviewed with Medical Director for accuracy and orders updated in the medical record as needed. Effective on October 3, 2016, the Clinical Manager or designee will conduct weekly audits focusing on vital signs every 30 minutes and heparin administered using the Flowsheet audit tool. The QAI committee will determine on-going frequency of the audits based on compliance. Once compliance, sustained monitoring will be done through the Medical Record 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.	

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V 726	Continued From page 9 used a CVC to dialyze. She said staff were trained to follow the Heparin infusion protocol. After examining the documentation, she said staff had been following protocol rather than following the orders on the treatment sheets for Patients #2 and #6. She said the orders were entered incorrectly and should have reflected the Heparin infusion protocol. Heparin infusion orders were not accurately entered into Patient #2's and #6's records.	V 726	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 ensure all documentation required to ensure the resolution of the deficiencies is provided to the QAI Committee on a monthly basis. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate.	