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
3232 Elder Street
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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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October 24, 2016

RECEIVED
NOV - 8 2016
FACILITY STANDARDS

Jennifer McMurrian, Administrator
Liberty Dialysis - Boise
1109 West Myrtle Street, Suite 120
Boise, ID 83702

RE: Liberty Dialysis - Boise, Provider #132528

Dear Ms. McMurrian:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis - Boise, which was conducted on October 18, 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 **November 7, 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
	132528	A. BUILDING _____ B. WING _____	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS - BOISE	1109 WEST MYRTLE STREET, SUITE 120 BOISE, ID 83702

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V 000	INITIAL COMMENTS CORE SURVEY The following deficiencies were cited during the recertification survey of your facility from 10/12/16 - 10/18/16. The surveyors conducting the survey were: Trish O'Hara, RN Team Leader Laura Thompson, RN Acronyms used in this report include: AVF - Arteriovenous Fistula BFR - Blood Flow Rate d/t - due to EDW - Estimated Dry Weight ICHD - Incenter Hemodialysis kg - kilogram ml/min - milliliters per minute PCT - Patient Care Technician PD - Peritoneal Dialysis pt - patient SBP - Systolic Blood Pressure	V 000		
V 113	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure proper hand hygiene was performed by 2	V 113		

RECEIVED
NOV - 8 2016
FACILITY STANDARDS

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

JOEL H. GROOMS | DIRECTOR OF OPERATIONS | 11/8/16

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 113	Continued From page 1 of 5 direct care staff (RN Clinical Manager and PCT A) who were observed during patient care. This had the potential for cross-contamination and infection of patient access sites. Findings include: A facility policy "Hand Hygiene," revised 3/20/13, stated hand hygiene will be performed, with an alcohol based hand rub or by washing hands with antimicrobial soap and water, after contact with inanimate objects near a patient and after removing gloves. This policy was not followed. During an observation beginning at 8:30 a.m. on 10/14/16, the RN Clinical Manager was attending to an alarm from a dialysis machine. She was wearing gloves and a gown. A second machine, 2 chairs away, began to alarm. The RN Clinical Manager walked from the first machine to the second one without removing her gloves and performing hand hygiene, then reset the alarm on the second machine. During the same observation, PCT A was attending to patients and dialysis machine alarms. She was observed removing her gloves and donning another pair of gloves, without performing hand hygiene in between. PCT A removed her gloves and donned a new pair of gloves, a minimum of 4 times during the observation. During an interview on 10/14/16 at 10:00 a.m., PCT A, PCT B and PCT C were interviewed regarding infection control and hand hygiene practices at the facility. They stated they received training and education upon hire during orientation, and then annually. PCT B stated hand hygiene was performed each time after	V 113		

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V 113	Continued From page 2 removing gloves, after touching a dialysis machine or surface in the patient area, and after direct contact with a patient. PCT B and PCT C stated they agreed with his statement. The facility failed to ensure staff followed the hand hygiene policy.	V 113		
V 452	494.70(a)(1) PR-RESPECT & DIGNITY The patient has the right to- (1) Respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that patients were treated with dignity and received individualized care. This failure directly impacted 1 of 3 ICHD patients (Patient #6) whose treatment sheets were reviewed and had the potential to impact all patients receiving care at the facility. The findings include: Patient #6 was a 69 year old female who had been dialyzing at the facility since 8/24/16. She had recently undergone surgery for a right knee replacement. Patient #6's record documented she arrived at the facility on 8/29/16 using an Iceman. This was an electrically powered cooling device, designed to control swelling and pain at Patient #6's surgical site. Patient #6 was not allowed to use the device while dialyzing. This was documented in a communication to her rehab facility on	V 452		

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V 452	Continued From page 3 8/29/16 that stated "We cannot plug pt's iceman in here d/t our outlets being designated for our dialysis machines only. We have ice packs here that we can put on pt's knee." However, no documentation was included in her record that showed ice bags were actually provided to Patient #6 in lieu of the device. In an interview on 10/18/16 at 10:30 a.m., the RN Clinical Manager reviewed Patient #6's record and confirmed there was no indication whether or not Patient #6 had received ice packs for her knee. The facility failed to provide individualized care to Patient #6.	V 452		
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 policy review, record review, and staff interview it was determined the facility failed to ensure an episode of severe intradialytic hypertension was addressed for 1 of 3 ICHD patients (Patient #6) whose treatment records were reviewed. This failure allowed the potential for a patient to experience complications of hypertension. The findings include: A policy titled Patient Monitoring During Patient Treatment, revised 8/20/14, directed staff to "Verify and react to unusual findings such as	V 543		

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V 543	Continued From page 4 atypical blood pressure readings." Patient #6 was a 69 year old female who had been dialyzing at the facility since 8/24/16. A review of 14 treatment sheets, from 8/24/16 - 9/30/16, showed her normal SBP was 80 - 120. A treatment sheet, dated 9/28/16 showed Patient #6 had a pre-dialysis seated blood pressure of 111/53. Her treatment was started at 8:25 a.m. At 9:02 a.m. Patient #6's blood pressure was measured at 193/178. The next documented measurement, at 9:32 a.m., was 219/204. There was no documentation present indicating the two significantly elevated measurements were acknowledged, verified, or treated by staff. In an interview on 10/18/16 at 10:30 a.m., the RN Clinical Manager stated Patient #6's elevated blood pressure could have been due to pain from her recent surgery. She confirmed there was no documentation showing staff reacted or intervened in response to the elevated readings. The facility failed to address Patient #6's hypertensive episode.	V 543		
V 559	494.90(b)(3) POC-OUTCOME NOT ACHIEVED-ADJUST POC If the expected outcome is not achieved, the interdisciplinary team must adjust the patient's plan of care to achieve the specified goals. When a patient is unable to achieve the desired outcomes, the team must- (i) Adjust the plan of care to reflect the patient's current condition; (ii) Document in the record the reasons why the patient was unable to achieve the goals; and	V 559		

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V 559	Continued From page 5 (iii) Implement plan of care changes to address the issues identified in paragraph (b)(3)(ii) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure EDW was appropriately assessed for 1 of 3 ICHD patients (Patient #6) whose treatment sheets were reviewed, and did not implement BFRs as prescribed for 2 of 3 ICHD patients (Patients #1 and #6.) These failures resulted in a patient leaving the facility at risk of complications from fluid overload and the potential for damage to AVFs for 2 patients. The findings include: 1. EDWs were not assessed as follows: Patient #6 was a 69 year old female who had been dialyzing at the facility since 8/24/16. A review of 14 treatment sheets, from 8/24/16 - 9/30/16, showed her normal SBP was 80 - 120. Patient #6's record documented continued signs and symptoms of fluid overload without intervention as follows: - A treatment sheet, dated 8/24/16 documented a physician ordered EDW of 87 kg. A pre-dialysis assessment documented shortness of breath, labored breathing, and 3+ weeping, pitting edema in both legs extending "from feet to mid-thigh." Post dialysis weight was documented as 90.4 kg. - A treatment sheet, dated 8/26/16, documented an EDW of 90.5 kg. A nursing assessment noted 3+ pitting edema in both legs as well as shortness of breath. Post dialysis weight was recorded as	V 559		

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V 559	Continued From page 6 91.9 kg. A physician's order increasing Patient #6's EDW from 87 kg to 90.5 kg was not included in her record. - A treatment sheet, dated 8/31/16, documented an EDW of 93.5 kg. A nursing assessment noted 3+ pitting edema in both ankles and lower legs as well as continued shortness of breath with rales and crackles in all four lung fields. A physician's order increasing Patient #6's EDW from 90.5 kg to 93.5 kg was not included in her record. - Six treatment sheets, from 9/2/16 - 9/12/16, documented an EDW of 92 kg while nursing assessments, for the same dates, documented continuing 3+ pitting bilateral lower extremity edema and shortness of breath with rales and crackles in bilateral lower lung fields. Treatment sheets from 8/26/16 - 9/28/16 had no documentation indicating Patient #6 experienced cramping, light headedness, or other symptoms contraindicating further fluid removal to address her fluid overload, documented in the assessments. In an interview on 10/18/16 at 10:30 a.m., the RN Clinical Manager confirmed the documentation on Patient #6's treatment sheets. She stated EDW changes were made by the physician. She stated she did not know why Patient #6's EDW were not changed to address the fluid overload noted in nursing assessments. 2. Prescribed BFRs were not implemented as follows: a. Patient #6 was a 69 year old female who had been dialyzing at the facility since 8/24/16. A	V 559		

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V 559	Continued From page 7 review of 15 treatment sheets, from 8/24/16 - 9/30/16, showed prescribed BFR was not adhered to during 14 treatments as noted: - Prescribed BFR was 450 ml/min and implemented BFR was 400 ml/min for the treatment on 8/24/16. - Prescribed BFR was 400 ml/min and implemented BFR was 450 ml/min for 12 treatments from 8/29/16 - 9/26/16, and on 9/30/16. - Prescribed BFR was 400 ml/min and implemented BFR was 550 ml/min for treatment on 9/28/16. In an interview on 10/18/16 at 10:30 a.m., the RN Clinical Manager confirmed the documentation on Patient #6's treatment sheets. She did not know why Patient #6's BFR was not implemented as prescribed. b. Patient #1 was a 64 year old male who began dialyzing at the facility on 9/16/16. Physician orders dated 9/14/16 stated the BFR was to run at 250 ml/min for the first dialysis treatment, then increase to 300 ml/min. The order stated the BFR was to be "Gradually increased to 400 over several treatments." The physician order for Patient #1's BFR was not adhered to as follows: - Treatment sheets, dated 9/16/16, 9/21/16, and 9/23/16, documented Patient #1's BFR was at 250 for the entire treatment. - The next treatment sheet, dated 9/26/16,	V 559		

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V 559	Continued From page 8 documented the BFR was increased to 350 for the entire treatment. Patient #1's BFR was increased from 250 to 350 after 3 dialysis treatments, 50 ml/min above what was ordered by his physician. - A treatment sheet, dated 9/28/16, 2 days after increasing Patient #1's BFR to 350, included treatment orders at the top of the document. The treatment orders stated Patient #1's BFR was 350. However, the BFR was increased again and set at 450 for the entire treatment. Patient #1's BFR was increased from 350 to 450 after 1 dialysis treatment, not several as ordered by his physician. - Patient #1's vascular access infiltrated twice on 10/03/16, after 2 treatments at the increased BFR of 450, and he was unable to receive his prescribed treatment. - Treatment sheets, dated 10/05/16, 10/07/16, 10/10/16, and 10/12/16, documented the treatment order for Patient #1's BFR was 350. However, the BFR was documented at 450 during each treatment. During an interview on 10/18/16 at 10:30 a.m., the RN Clinical Manager reviewed the treatment records and confirmed the increased BFR for Patient #1. She confirmed the physician order was not followed for increasing the BFR. She stated because she was using a larger gauge needle and the needle was able to accommodate the increased flow, she was able to increase the BFR at a faster rate. The RN Clinical Manager confirmed the BFR was not changed on the treatment sheet, to reflect the increased flow.	V 559		

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V 559	Continued From page 9 The facility failed to ensure staff implemented the physician's order for Patient #1's BFR.	V 559		

Plan of Correction

Documentation

V-tags	Action Plan	Completion
V 113	On 10/21/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on policies: • FMS-CS IC- II- 155-090A Hand Hygiene Policy Emphasis was placed on: • Staff will perform hand hygiene using hand sanitizer or washing hands. Must be done after removing gloves. Must remove gloves and perform hand hygiene between each patient station. Effective 10/21/16, Clinical Manager or designee will conduct daily audits utilizing Infection Control Audit tool for 4 weeks. The QAI committee will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the clinic audit checklist 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 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 11/21/16.	11/21/16

Plan of Correction

Documentation

V-tags	Action Plan	Completion
V 452	On 10/21/16, the Clinical Manager held a Staff meeting with all DPC and ancillary staff reinforcing the expectations and responsibilities of the facility staff on policies: • (FMS-CS-IC-I-103-005A) – Patient Rights and Responsibilities) • (FMS-CS-IC-I-103-005D1) – Patient Rights and Responsibilities List (Questionnaire) • (Conditions for Coverage V-Tag – 452) Produced to staff for review at Daily huddles starting on 10/31/16 placing emphasis on dignity and respect of patients. Emphasis was placed on: (examples below) – NOTE: Emphasis is placed on the particular area of the policy that was not in compliance • Eg. Reviewed example of "Iceman" to staff for review at Daily huddles starting on 10/31/16, placing emphasis on dignity and respect of patients. Staff were educated on the impacts of poor communication and not reporting timely to the CM. Effective 10/21/16, Clinical Manager and MSW or designee will conduct an audit on all patients utilizing the patient rights and responsibilities questionnaire looking to identify any patients who have requested needs or feel their respect and dignity is not being met. Based upon the results from the questionnaire to be completed by November 30th, 2016. The QAI committee will determine on-going frequency of the audits based on the patient response or results of questionnaire. Once compliance sustained monitoring will be done through the patients' rights and responsibility questionnaire it will be reported through the QAI process. 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	11/30/16

	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 11/30/16.	

Plan of Correction

Documentation

V-tags	Action Plan	Completion
		11/21/16
V 543	On 10/21/16, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on the following policies: 1. FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy Emphasis was placed on the requirements to ensure staff practice: 1. Ensure all episode of severe hypertension are addressed. 2. Staff will appropriately handle and document low and high blood pressure issues and follow up with appropriate documentation. Effective on 10/21/16, the Clinical Manager or designee will conduct weekly audits on 50 % of patient flowsheets for 4 consecutive weeks focusing on high blood pressures by using the Medical Record audit tool. The QAI committee will determine frequency of audits based on results. Once compliance sustained monitoring will be done through the Medical Record audits and per QAI calendar 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 11/21/16.	

Plan of Correction

Documentation

V-tags	Action Plan	Completion
V 559	On 10/21/16, the Clinical Manager held a staff meeting and reinforced 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-I-110-149A Nursing Supervision and Delegation Policy Emphasis was placed on the requirements to ensure staff practice: 1. All patients expected outcomes are achieved and if not the interdisciplinary team must adjust the patients plan of care. 2. Patients will be monitored per policy and ensure they are documenting interventions as per policy and procedure. Effective 10/21/16, Clinical Manager or designee will conduct weekly patient flowsheet audits, auditing 50% of all patients, utilizing Medical Record Audit tool for 4 weeks. Emphasis of audits will be placed on estimated dry weights and blood flow rates. 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. 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	11/21/16

	providing resolution of the issues. The in-service sheets are available in the clinic for review. The deficiency was corrected on 11/21/16.	