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
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 24, 2017

Regina Souza, Administrator
U S Renal Care Hayden Dialysis
8556 Wayne Drive
Hayden, ID 83835

RE: U S Renal Care Hayden Dialysis, Provider #132519

Dear Ms. Souza:

This is to advise you of the findings of the Medicare survey of U S Renal Care Hayden Dialysis, which was conducted on March 17, 2017.

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 **April 6, 2017,** 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 WISNOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

U.S. | **RENAL** CARE

April 4, 2017

Nicole Wisnor, Supervisor
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RECEIVED
APR 06 2017
FACILITY STANDARDS

RE: US RENAL CARE HAYDEN DIALYSIS, Provider #132519

Dear Ms. Wisnor,

Attached please find the plan of correction (POC) for the Medicare survey findings conducted on March 17, 2017. Please let me know if you require any further information.

Sincerely,

Patty Plummer, RN
Facility Administrator
US Renal Care Hayden Dialysis
CCN#132519

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132519	A. BUILDING ______ B. WING ______	03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U S RENAL CARE HAYDEN DIALYSIS	8556 WAYNE DRIVE HAYDEN, ID 83835

(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 SURVEY The following deficiencies were cited during the recertification survey of your facility from 3/13/17 - 3/17/17. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: CVC - Central Venous Catheter FA - Facility Administrator ICHD - In Center Hemodialysis IDT - Interdisciplinary Team PCT - Patient Care Technician POC - Plan Of Care PD - Peritoneal Dialysis QIP - Quality Improvement Project	V 000		
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or	V 147	RECEIVED APR 06 2017 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Plummer, RN
TITLE: Facility Administrator
(X6) DATE: 4/4/2017

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 147	Continued From page 1 other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This STANDARD is not met as evidenced by: Based on observations, staff interview, and policy review it was determined the facility failed to ensure cross contamination was avoided for 1 of 2 patients (Patient #5) observed, who dialyzed using a central venous catheter. This failure had the potential to impact all patients, dialyzing with central venous catheters at the facility, by exposing patients to the potential for access acquired blood stream infections. Findings include: A policy titled Proper Utilization Of The Dialysis Catheter, revised 6/2016, instructed staff to "use strict aseptic technique" when accessing and deaccessing CVCs for dialysis treatments. During an observation on 3/14/17 at 12:30 p.m., PCT A was accessing Patient #5's CVC for treatment. The PCT applied gloves to her hands and pulled protective goggles into position from the top of her head, making gloved contact with	V 147	*All staff will be in-serviced and the following policies will be reviewed:* *1) Hand Hygiene C-IC-0060* *2) Infection Control and Precautions for all Patients C-IC-0010* *3) Proper Utilization of Dialysis Catheter C-TI-0090.* *Focus of the in-service include avoiding possible contamination of the catheter patient by using aseptic techniques when accessing and de-accessing catheter including, but not limited to, proper hand hygiene and proper use of personal protective equipment (PPE)* *Compliance to proper dialysis catheter care will be monitored by the Facility Administrator through completing infection control audits by the FA or designee daily x 2 weeks then weekly until 95% compliance is reached and maintained x 3 weeks, then monthly.* *Audit results will be discussed in monthly staff and QAPI meetings for improvements and correction/revision to plan if needed.*	*3/28/17* *4/28/17* *4/29/17*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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V 147	Continued From page 2 her hair. She adjusted her mask with gloved hands. She then proceeded to handle the hubs of Patient #5's CVC without changing gloves. When the PCT was made aware of the cross contamination she said "I never thought about that." The facility failed to ensure staff did not cross contaminate Patient #5's CVC.	V 147		
V 557	494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure initial POCs were developed and implemented in a timely manner for 3 of 5 ICHD patients (Patients #3 - #5) whose records were reviewed. This failure created the potential for the patients' initial needs to remain unassessed and unaddressed. Findings include: 1. Patient #3 was a 74 year old female who had been admitted to ICHD on 2/4/17. Her initial POC was due on 3/6/17. On 3/17/17 Patient #3's POC was awaiting review and approval by the IDT. 2. Patient #4 was a 33 year old male who had been admitted to ICHD on 2/11/17. He was dialyzing in center until his new PD catheter was	V 557	*Emergent Governing Body meeting with the the Interdisciplinary Team (IDT) was done to to review Comprehensive Interdisciplinary Patient Assessment and Plan of Care policy C-AD-0490. Review included initiating comprehensive assessment and developing plan of care on all new patients and any patient that changed and became fully dependent on new modality within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session.* *Delinquent Plan of Care will be re-initiated and completed by 3/31/2017* *The Facility Administrator will ensure initial assessment and plan of care on all patients are completed and implemented in a timely manner. Medical records audit to be completed on 100% of patient census by 3/31/2017, then 10% of patient census monthly. The Facility Administrator or designee will maintain a tracking log to monitor who and when assessment is due.* *Audit results will be discussed in monthly staff and QAPI meetings for improvements and correction/revision to plan if needed.*	*3/20/17* *3/31/17* *3/31/17* *4/29/17*

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V 557	Continued From page 3 able to be used. His initial POC was due on 3/13/17. On 3/16/17 Patient #4 was dialyzing in center and no POC had been developed or implemented. 3. Patient #5 was a 75 year old male who had been admitted to ICHD and PD on 12/21/16. A PD POC, dated 1/26/17 was documented. However, Patient #5's treatment records showed he had dialyzed in center from 12/21/16 - 1/24/17. He had dialyzed at home, using PD, from 1/25/17 - 2/1/17. He returned to ICHD on 2/2/17. No ICHD POC was present on 3/16/17. In an interview on 3/16/17 at 4:00 p.m., the interim FA said review and approval of POCs for all patients occurred during monthly rounding with the physician. In the same interview, the interim FA confirmed the missing/late POCs. She said PD patients often used "back up" hemodialysis but were considered, by the facility, to still be PD patients. The facility failed to ensure appropriate and timely POCs were developed and implemented.	V 557		
V 772	494.180(i) GOV-RESPONDS TO NW REQUEST/WORKS TOWARD GOALS The governing body receives and acts upon recommendations from the ESRD network. The dialysis facility must cooperate with the ESRD network designated for its geographic area, in fulfilling the terms of the Network's current statement of work. Each facility must participate in ESRD network activities and pursue network goals.	V 772		

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V 772	Continued From page 4	V 772		
	This STANDARD is not met as evidenced by: Based on communication with the Network and staff interview, it was determined the governing body failed to ensure the facility responded promptly to deadlines for data requested by the Network. This failure had the potential to impact all patients dialyzing at the facility by compromising the facility's ability to improve patient care quality and safety. The findings include:		*An emergent Governing Body meeting was conducted on 3/20/17 to review the citations mentioned at the exit conference at the conclusion of the external survey on 3/17/17*	*3/20/17*
			Moving forward, at the direction of the Governing Body and the Medical Director, the Facility Administrator will ensure the facility responds promptly to deadlines for data on any and all Quality Initiative Activity (QIA) requested by Renal Network. All required reports and data for QIP project on decreasing blood stream infections will be submitted by 3/31/17.	*3/31/17*
	The Network was contacted by telephone, on 3/17/17, at the time of survey entrance. The Network reported the facility was enrolled in a QIP for decreasing blood stream infections. The requirements for enrollment in this project included self reporting access care audit results to the Network on a monthly basis. However, the Network said the facility was "non-compliant" in the reporting responsibilities having not submitted data for the first month of the project, February, 2017.		*Status of all Renal Network projects will be reported at the monthly QAPI meetings to ensure compliance as well as evaluation and/or revision of plan if needed.*	*4/29/17*
	In an interview on 3/15/17 at 1:30 p.m., the interim FA confirmed the facility had not submitted data to the Network for February, 2017. She said the former FA had resigned and left the facility around March 1, 2017 without completing or submitting the required data.			
	The governing body failed to ensure the facility provided data to the regional Network in a timely manner.			