IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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June 21, 2018

Joel Grooms, Administrator
Liberty Dialysis Caldwell
4620 Enterprise Way, Suite 101
Caldwell, ID 83605-6764

RE: Liberty Dialysis Caldwell, Provider #132523

Dear Mr. Grooms:

Based on the survey completed at Liberty Dialysis Caldwell, on June 15, 2018, by our staff, we have determined Liberty Dialysis Caldwell is out of compliance with the Medicare ESRD Condition for Coverage of **Water & Dialysate Quality (42 CFR 494.40)**. To participate as a provider of services in the Medicare Program, an ESRD must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Liberty Dialysis Caldwell, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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 each form.

Such corrections must be achieved and compliance verified by this office, before July 30, 2018. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than July 16, 2018.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **July 3, 2018**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

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
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132523	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS CALDWELL	4620 ENTERPRISE WAY, SUITE 101 CALDWELL, ID 83605

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey at your facility from 6/11/18 - 6/15/18. The surveyors conducting the survey were: Trish O'Hara, RN, HFS, Team Lead Brian Osborn, RN, HFS Acronyms used in this report include: AMA - Against Medical Advice CM - Clinic Manager ICHD - In Center Hemodialysis MSW - Master prepared Social Worker PCT - Patient Care Technician Pt - Patient QAPI - Quality Assurance Performance Improvement RN - Registered Nurse Tx - Treatment	V 000	RECEIVED JUN 25 2018 FACILITY STANDARDS	
V 175	CFC-WATER & DIALYSATE QUALITY CFR(s): 494.40 This CONDITION is not met as evidenced by: Based on observations, staff interview, and procedure review, it was determined the facility failed to ensure the delivery of safe product water for patient dialysis treatments. This failure placed all facility patients at risk of potential adverse exposure events. The findings include: 1. Refer to V220 as it relate to the facility's failure to ensure appropriate testing was done for machine residual chlorine after disinfection and before patient treatments.	V 175		

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

DIRECTOR OF OPERATIONS 6-25-18

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 220	BACT CONTROL-SUPPLY LINE DISINFECTED CFR(s): 494.40(a) 7 Strategies for bacterial control 7.1 General: machine supply line disinfected Users should establish a procedure for regular disinfection of [the line between the outlet from the water distribution system and the back of the dialysis machine]. This STANDARD is not met as evidenced by: Based on observation, procedure review, and staff interview, it was determined the facility failed to ensure patients were protected from potential exposure to unsafe free chlorine levels. This failure impacted all patients dialyzing at the facility and put them at risk of adverse reactions to chlorine exposure. The findings include: Mosby's Review of Hemodialysis for Nurses, 9th edition, 6/15/15, defined hemolysis as the break up of the red blood cells resulting in the release of hemoglobin and intracellular potassium. This reference also stated one cause of hemolysis was exposure to sodium hypochlorite (bleach), and stated "acute hemolysis during the dialysis treatment is a medical emergency." During observations in the facility treatment area, on 6/14/18 at 11:35 AM, a bottle of WaterCheck RC Residual Chlorine test strips was examined. The opened date was Thursday, 6/07/18. However, the expiration date of the strips was 4/2018. Four strips were missing from the bottle. It was unclear on which dialysis machines the missing strips had been used. Immediate investigation of the supply storage area, accompanied by the CM and RN B, determined 24 additional bottles of test strips,	V 220		

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V 220	Continued From page 2 with the expiration date 4/2018, were available to staff for use. Facility procedure titled "Testing for Residual Bleach Using WaterCheck RC Residual Chlorine Reagent Test Strips," dated 8/20/14, stated "DO NOT: ... Use the strip after manufacturer's expiration date (opened or unopened bottle)." In an interview at the time of the observations, the CM confirmed the presence of expired residual chlorine strips in the treatment area. He stated all thirteen dialysis machines in the treatment area were routinely disinfected with chlorine bleach every Tuesday night. He stated every Wednesday morning the machines were tested with the strips, to determine the absence of chlorine bleach, prior to patient treatments. In the same interview, PCT E stated he had finished a bottle of test strips on Wednesday morning, 6/13/18, but did not know where the expired bottle of test strips in question had been used. While removing the 24 bottles of expired test strips from the supply storage area, at 11:45 AM on 6/14/18, the CM stated it was primarily the responsibility of the person opening a new bottle to check the expiration date, and secondarily the responsibility of the biomed technician to check for expiration of all supplies in the area. The facility failed to ensure patients were protected from potential harm from bleach exposure.	V 220		
V 628	QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS	V 628		

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V 628	Continued From page 3 CFR(s): 494.110(a)(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Based on adverse event and AMA form review, treatment sheet review, and staff interview, it was determined the facility failed to ensure patient data was accurately collected. This failure directly impacted 4 of 7 ICHD patients (Patients #1, #2, #3, and #6) whose records were reviewed, and had the potential to impact all patients receiving care at the facility. This failure resulted in the inability to identify problem indicators, and the inability to devise an effective action plan to correct the problem indicators. The findings include: A review of facility QAPI meeting minutes from 3/2018 - 5/2018 showed the QAPI committee reviewed facility data, including data related to adverse events and AMAs, and based process changes and action plans on the data received and reviewed. 1. Data collection did not accurately reflect adverse events occurring at the facility. A policy titled "Patient Adverse Event Reporting and Documentation," dated 1/04/12, listed 90 occurrences for which an adverse event report was to be generated.	V 628		

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V 628	Continued From page 4 Examples of occurrences not appropriately reported as adverse events included, but were not limited to, the following: - The adverse event report list included "inability to cannulate." Patient #2 was a 27 year old male who presented for treatment on 5/25/18. Nursing notes documented "Unable to start treatment today after 4 cannulation attempts clotted." No adverse event report could be located for this occurrence. - The adverse event report list included "Infiltration severe enough to interfere with dialysis treatment." Patient #1 was a 23 year old male who dialyzed at the facility on 6/01/18. Nursing notes documented "Tx. ended 2 hrs 5 min early as venous needle infiltrated post pt went to bathroom." No adverse event report could be located for this occurrence. - The adverse event report list included "Abusive/Violent behavior" and "Any patient incidents that involve...possession of a dangerous weapon." Patient #1 had been included on the facility's unstable patient list during the months of May and June, 2018, for abusive behavior as evidenced by "making aggressive comments toward staff." No adverse event reports could be located, related to abusive behavior occurrences, prior to Patient #1 being placed on the unstable list for abusive behavior. Additionally, during an interview on 6/12/18 at	V 628		

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V 628	Continued From page 5 9:00 AM, the MSW stated that, on an unknown date during the 2 month unstable period, she was visiting with Patient #1 at the chairside. During the visit she discovered Patient #1 had a knife in his possession. She described this as "larger than a pocket knife." She confiscated the knife from him. No adverse event report could be located for this occurrence. In an interview on 6/14/18 at 2:25 PM, the CM confirmed no adverse event reports had been generated for the occurrences with Patients #1 and #2. Adverse event data was not accurately collected for QAPI review. 2. Data collection did not accurately reflect AMA events occurring at the facility. A policy titled "Early Termination or Arriving Late for Treatments", dated 7/04/12, stated AMA forms were to be signed for the two circumstances included in the title. No other circumstances were included. AMA forms reviewed included the statement "I am requesting to terminate my treatment prior to prescribed time" and were signed by the patients involved. Examples of AMA forms being signed by patients for reasons other than patient request or due to late arrival for treatment included, but were not limited to, the following: - Patient #2 was a 27 year old male who presented for treatment on 5/25/18. An AMA form was signed indicating Patient #2 had	V 628		

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V 628	Continued From page 6 requested early termination of treatment. A nursing note was included stating "Unable to perform treatment today after 4 cannulation attempts. [Patient's name] is unable to come tomorrow due to travel plans." - Patient #1 was a 23 year old male who dialyzed on 6/01/18. An AMA form was signed indicating Patient #1 had requested early termination of treatment. A nursing note was included stating "Off 2 hrs 5 min early. Pts venous needle infiltrated and pt will come in tomorrow for make up tx. Pt had just returned from bathroom." - Patient #6 was a 38 year old patient who dialyzed on 5/24/18. His treatment had been shortened by 85 minutes. An AMA form was signed indicating he had requested early termination of treatment. A nursing note was included stating "unable to run full tx due to unit demands today." - Patient #3 was a 43 year old female who dialyzed on 6/05/18. Her 4 hour prescribed treatment had been shortened by 3 hours and 40 minutes. An AMA form was signed indicating she had requested early termination of treatment. A nursing note was included stating "Tx ended post 20 min due to flows less than 100 and constant alarms." In an interview on 6/14/18 at 2:25 PM, the CM confirmed the AMA forms for Patients #1, #2, #3, and #6 were not accurate. AMA data was not accurately collected for QAPI review.	V 628		

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E 000	Initial Comments The Medicare recertification survey of your facility, including Emergency Preparedness, was conducted on 6/11/18 to 6/15/18. Surveyors conducting the Medicare recertification survey were: Trish O'Hara, RN, HFS, Team Lead Brian Osborn, RN, HFS Acronyms used in this report include: ATOM - Area Technical Operations Manager CM - Clinic Manager CMS - Centers for Medicare and Medicaid Services LEA - Law Enforcement Agency LMSW - Licensed Medical Social Worker LPN - Licensed Practical Nurse PCT - Patient Care Technician RD - Registered Dietician RN - Registered Nurse	E 000	RECEIVED JUN 2 5 2018 FACILITY STANDARDS	
E 030	Names and Contact Information CFR(s): 494.62(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians	E 030		

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E 030	Continued From page 1 (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E 030		

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E 030	Continued From page 2 (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on emergency preparedness document review and staff interview, it was determined the facility failed to document a communication plan which included accurate contact information for staff. Failure to have a communication plan which included accurate staff information had the potential to hinder both internal and external emergency response efforts. Findings include: A facility emergency preparedness document "'Emergency' phone tree," undated and unsigned, listed 5 staff positions with outdated names and phone numbers: - Clinical Manager, Boise - Administrative Assistant, Boise - ATOM, Boise - Biomed, Caldwell - Biomed, Meridian/Acutes It was unclear who held the above positions and what their contact information was. The CM was interviewed on 6/14/18, beginning at 9:53 AM, and the facility phone tree document was reviewed in his presence. He confirmed the 5 staff position's contact information was outdated and not accurate.	E 030		

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E 030	Continued From page 3 The facility failed to ensure their emergency communication plan included accurate staff information.	E 030		
E 033	Methods for Sharing Information CFR(s): 494.62(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.	E 033		

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E 033	Continued From page 4 *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on emergency preparedness document review, observation, and staff interview, it was determined the facility failed to ensure a current plan for sharing patient medical documentation during an emergency for 62 of 62 in-center hemodialysis patients and 25 of 25 peritoneal dialysis patients, whose emergency medical documentation was reviewed. This lack of a current plan for sharing patient medical documentation with other health care providers had the potential to hinder the facility's ability to continue care during a disaster. Findings include: A facility document "EMERGENCY PREPAREDNESS FOR DIALYSIS FACILITIES," undated and unsigned, stated: - "Active medical records, including resuse records, should be secured and protected to minimize damage from wind, rain, broken glass, sprinklers, chemicals, etc." - "In a disaster, records may be destroyed, unavailable, mutilated or unusable. An inexpensive but efficient method to have a back-up medical record for all of your patients..." - "Copy the Medical Evidence Form (CMS 2728), the hemodialysis orders, admitting face sheet for ALL of your patients and place them in a three-ring binder...keep the binder in the 'emergency box.'"	E 033		

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E 033	Continued From page 5 This plan was not followed. Examples include: 1. An observation of the facility treatment floor was conducted in the presence of RN A on 6/12/18, beginning at 3:05 PM. During the observation, the facility patient emergency binder, which included demographic information for 62 of 62 in-center hemodialysis patients, was reviewed. For each in-center hemodialysis patient, the following 3 elements were missing: - Medical Evidence Forms (CMS 2728) - Hemodialysis orders - Admitting face sheets Additionally, the facility "emergency box" could not be located. The CM was interviewed on 6/14/18, beginning at 9:53 AM, and the emergency preparedness document was reviewed in his presence. When asked if the facility had an emergency box, he stated no. When asked if the facility had Medical Evidence Forms (CMS 2728), hemodialysis orders, and admitting face sheets printed for each in-center hemodialysis patient, the CM stated no. In-center hemodialysis patient medical documentation was not available in the event of an emergency. 2. The Home Therapies Program Manager was interviewed on 6/15/18, beginning at 11:35 AM, and the emergency preparedness document was reviewed in her presence. When asked if the home therapies department participated in the facility's emergency preparedness plan, she	E 033		

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	132523	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 033	Continued From page 6 stated no. The Home Therapies Program Manager stated 25 of 25 peritoneal dialysis patient demographic and clinical information was available online only. She stated "hopefully the Internet doesn't go down." The Home Therapies Program Manager confirmed Medical Evidence Forms (CMS 2728), peritoneal dialysis orders, and admitting face sheets for each peritoneal dialysis patient was not printed. Home therapies patient medical documentation was not available in the event of an emergency.	E 033		
E 038	ESRD EP Training Program CFR(s): 494.62(d)(1) (d)(1) Training program. The dialysis facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. Staff training must: (iii) Demonstrate staff knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under	E 038		

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E 038	Continued From page 7 such emergency conditions); and (D) How to disconnect themselves from the dialysis machine if an emergency occurs. (iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and (v) Properly train its nursing staff in the use of emergency equipment and emergency drugs. (vi) Maintain documentation of the training. This STANDARD is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure staff were able to demonstrate knowledge of emergency procedures. This resulted in staff being unable to speak to their role in the facility's emergency preparedness plan. Findings include: RD H was interviewed on 6/12/18, beginning at 12:15 PM. When asked what her role in an emergency entailed, she stated "to educate patients." RD H stated she was unaware of any new emergency preparedness plan after November 2017. LMSW G was interviewed on 6/12/18, beginning at 8:57 AM. When asked what her role in an emergency entailed, she stated "fire drills." LMSW G stated she was unaware of any new emergency preparedness plan after November 2017. RN A was interviewed on 6/12/18, beginning at 3:05 PM. When asked what her role in an emergency entailed, she stated she was "unaware." RN A stated she had not seen the facility's emergency preparedness plan. RN B was interviewed on 6/14/18, beginning at 9:40 AM. When asked what her role in an emergency entailed, she stated "code blue." RN	E 038		

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E 038	Continued From page 8 B stated she was not familiar with the facility's emergency preparedness plan. PCT E was interviewed on 6/15/18, beginning at 9:50 AM. When asked what his role in an emergency entailed, he stated he was unsure. PCT E stated he was not familiar with the facility's emergency preparedness plan. PCT F was interviewed on 6/15/18, beginning at 9:50 AM. When asked what her role in an emergency entailed, she stated she was unsure. PCT E stated she was unaware of the facility's emergency preparedness plan. RN C, RN D, and LPN I, all home therapies staff, were interviewed together on 6/15/18, beginning at 10:20 AM. When asked what their role in an emergency entailed, they stated they had not received training, did not participate in the emergency plan, and did not participate in drills. RN C, RN D, and LPN I stated they did not hear specifics on a new emergency preparedness plan after November 2017. The Home Therapies Program Manager was interviewed on 6/15/18, beginning at 11:35 AM. When asked if the home therapies department participated in the facility's emergency preparedness plan, she stated no. The Home Therapies Program Manager stated she was not familiar with the facility's emergency preparedness plan. Facility staff failed to demonstrate knowledge of emergency procedures.	E 038		
E 039	EP Testing Requirements CFR(s): 494.62(d)(2)	E 039		

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E 039	Continued From page 9 (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 10 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on emergency preparedness document review and staff interview, it was determined the facility failed to ensure emergency preparedness exercises were conducted. This had the potential for facility staff to be unprepared in the event of an internal or external disaster. Findings include: A facility document "Dialysis Facility Incident After Action Report/Improvement Plan," dated 1/09/18, documented an "active shooter drill" which was conducted with local LEA at a sister facility in a nearby city. The report listed names of facility staff and administration, but did not include staff signatures or what role they played in the drill. The following 7 staff were documented as having attended the drill: - RN A - RN B - PCT E	E 039		

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E 039	Continued From page 11 - PCT F - LMSW G - RD H - Home Therapies Program Manager LMSW G was interviewed on 6/12/18, beginning at 8:57 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, LMSW G stated no. RD H was interviewed on 6/12/18, beginning at 12:15 PM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, RN H stated no. RN A was interviewed on 6/12/18, beginning at 3:05 PM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, RN A stated no. RN B was interviewed on 6/14/18, beginning at 9:40 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, RN B stated no. PCT E was interviewed on 6/15/18, beginning at 9:50 AM. When asked if he attended the "active shooter drill" on 1/09/18, she stated no. When asked if he was aware of the drill and its results, PCT E stated no. PCT F was interviewed on 6/15/18, beginning at 9:50 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results,	E 039		

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E 039	Continued From page 12 PCT F stated no. RN C was interviewed on 6/15/18, beginning at 10:20 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, RN C stated no. RN D was interviewed on 6/15/18, beginning at 10:20 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, RN D stated no. LPN I was interviewed on 6/15/18, beginning at 10:20 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, LPN I stated no. The Home Therapies Program Director was interviewed on 6/15/18, beginning at 11:35 AM. When asked if she attended the "active shooter drill" on 1/09/18, she stated no. When asked if she was aware of the drill and its results, the Home Therapies Program Director stated no. The CM was interviewed on 6/15/18, beginning at 11:55 AM, and the emergency drill was reviewed in his presence. He confirmed the above staff did not attend the drill. Additionally, he confirmed the drill review with facility staff was not documented. He confirmed a second community-based and/or facility-based emergency preparedness exercise had not been performed. Facility staff failed to participate in 2 community-based and/or facility-based emergency preparedness exercises.	E 039		

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Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

V175 CfC: 494.40 Water and Dialysate Quality

The Governing Body of Caldwell Dialysis facility acknowledges its responsibility to ensure that systems are in place that provide safe product water and dialysate to all patients for the patient dialysis treatments as required by the Conditions for Coverage.

The Governing Body (GB), on 6/19/2018, reviewed the findings to be reported in the Statement of Deficiencies (SOD) and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The following action steps were implemented.

Starting 6/19/2018, the Governing Body will meet weekly to monitor the progress of the Plan of Correction. Continuation of the meetings will be determined by the governing body based on the progress of the plan and that the corrective actions have resulted in resolution of the cited issues. Once sustained resolution is determined by the Governing Body, they will return to quarterly or as needed Governing Body meetings.

Effective immediately:

- The Clinical Manager and or the Director of Operations will analyze and trend all data and monitoring/audit results as related to this plan of Correction prior to presenting the monthly data to the QAPI Committee.
- A specific plan of action encompassing the citation as cited in the Statement of Deficiencies has been added to the facility's monthly QAPI agenda.
- The QAPI committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The **Director of Operations (DO)** will present a report to the GB meeting on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.
- **The Governing Body will review the audit results and determine when there can be a reduction in the frequency of the audits. All audits and reviews will be summarized and reported to the Governing Body weekly.**
- Minutes of the Governing Body and QAPI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAPI Committee's ongoing monitoring of facility activities. These are available for review at the facility.

The Governing Body, at its meeting on 6/19/2018, designated the **Director of Operations** to serve as Plan of Correction Monitor and provide additional oversight. They will **participate in QAPI and Governing Body meetings.** This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

The responses provided for V220 describes, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

V220

On 6/26/2018, 6/27/2018, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on Policies:

- FMS-CS-IC-II-140-800C Testing for Residual Bleach Using Water Check RC Residual Chlorine Reagent Test Strips

Educational Emphasis was placed on:

- Ensure all patients are protected from potential exposure to unsafe free chlorine levels.
- Ensure direct patient care staff verify the expiration of test strips before using the bottle.
- On 6/29/2018, CM held a huddle for all direct patient care staff to educate on validating when opening a new bottle with the open date, expiration date, and confirm test strips are valid. This will be documented in the Total Maintenance System.
- On 6/15/2018, all expired Residual Bleach test strips were disposed of, and replenished with new supply.
- Ensure Stock rotation of all RC Residual Chlorine Reagent Test Strips. Stock will be rotated bi-weekly when dialysis supplies are delivered to the facility. With the new test strips being placed in the back, and the old test strips being moved to the front for use first.
- Ensure direct patient or non-direct patient care staff perform monthly stock room audit checking expiration dates when counting inventory.
- On 6/15/2018, Clinic Manager and Biomed went through all supplies to ensure no expired strips were present in the clinic.
- On 6/19/2018, Total Maintenance System Reports were ran to do a 100% audit of all strips that were documented and used on the machines, to check for residuals strips documented as expired. None were found.
- A new Biomed Technician has been hired for this facility. They will be over the inventory and supplies, stocking and storage. Until the biomed has been fully trained, the monitoring of stocks and supplies will be done by the Clinic Manager or designee.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service on 6/29/2018.

Effective 6/20/2018, Clinical Manager or designee will conduct Bi-weekly audits after delivered dialysis supplies have been stocked, utilizing Audit tool for 8 weeks. Monthly inventory count will include rotation of expiration dates for test strips, Clinic Manager or Designee will monitor monthly for 3 months. These audits will take place until the rotation of stock in the supply room continues to stay organized with expiration dates. The Governing Body will determine on-going frequency of the audits based on compliance. Once 100% compliance is sustained monitoring will be done with the Biomed Technical logs with Quality Assessment Improvement continuing with the Quality Assessment Improvement calendar on a monthly basis.

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

The Clinical Manager 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 Quality Assessment Improvement Committee monthly.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

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 Quality Assessment Improvement 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 Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

V628

On 6/26/2018, 6/27/2018, the Clinical Manager held a staff meeting and reinforced the expectations and responsibilities of the facility staff on Policies:

- FMS-CS-IC-I-101-001A Quality Assessment and Performance Improvement Program (QAPI) Policy
- FMS-CS-IC-II-165-001A Patient Adverse Event Policy

Educational Emphasis was placed on staff practice:

- LMS adverse event training done for all staff, to ensure the knowledge of what is an adverse event.
- Ensure complete documentation in accordance with Quality Assessment Improvement and Adverse Event Policies is followed.
- Ensure event is documented in patient health record.
- Ensure event has been entered into the Adverse Event Summary for Hemodialysis or Peritoneal Dialysis.
- Ensure Clinic Manager is notified of Adverse Event.
- Ensure the Quality Assessment and Performance Improvement Program held monthly, Reviews and evaluates each individual Adverse Event. Trending patient safety, outcome, and ways to prevent said event if applicable.
- Ensure if trend is found, Root Cause Analysis is completed, and documented in Quality Assessment Improvement.
- Ensure Action plan is created to work and update the process of the analysis and the progress of initiations.
- Ensure Governing Body minutes reflect the update of trend findings, and discussion of Quality Assessment Improvement process.
- Direct patient care staff will not use AMA (Against Medical Advice) sign sheet for infiltrations, when treatment cannot resume same day.
- On 6/26/2018 and 6/27/2018, patient education was done on AMA's, following physician's orders, by completing full treatments. Documentation has been placed in the eCube Clinical program of the patient's electronic record.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service on 6/29/2018.

Effective 6/20/2019, Clinical Manager or designee will conduct Bi-weekly preparation for Quality Assessment Improvement using eQuip Adverse event entry log tool with documentation of checking Adverse Events from Staff. Quality Assessment Improvement minutes to include a greater focus on adverse events and their outcomes for the next 3 months. The Governing Body will determine on-going frequency of the audits based on compliance. Once 100% compliance is sustained monitoring will be done through the eQuip Adverse Event entry log Audit per the Quality Assessment Improvement calendar, on a monthly basis.

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

The Clinical Manager 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 Quality Assessment Improvement Committee monthly.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

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 Quality Assessment Improvement 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 Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

E030

On 6/26/2018, 6/27/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D3 Emergency Disaster Staff Contact Information Sheet

Education emphasis was placed on:

- On 6/25/2018, the old employee communication chart labeled "Emergency Phone Tree" was removed, has been updated with current address and phone numbers with all employees. This has been placed in the facility specific emergency plan book for Caldwell.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on/will be delivered by 6/29/2018.

On 6/19/2018, Clinical Manager held Governing Body meeting to go over the updates to the emergency plan. The Governing Body will continue on-going annual review of the Emergency plan and point of contact with the local disaster management team. This will be covered annually in the Quality Assessment Improvement meeting.

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

The Clinical Manager 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 Quality Assessment Improvement 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 Quality Assessment Improvement Committee is responsible to provide oversight, review finders, 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.

Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

E033

On 6/26/2018, 6/27/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D4 Emergency Disaster Patient Contact Information Sheet

Education emphasis was placed on:

- Patient treatment orders, and face sheet will be updated quarterly and placed in the secured crash cart/Emergency box. In Quality Assessment Improvement meeting quarterly.
- On 6/29/2018, In-center patient treatment orders were printed, and placed in the secure emergency box.
- On 6/29/2018, In-center patient 2728's were copied, and placed in the secure emergency box.
- On 6/29/2018, In-center patient Face sheets were printed, and placed in the secure emergency box.
- On 6/29/2018, Home patient treatment orders were printed, and placed in the secure emergency box.
- On 6/29/2018, Home patient 2728's were copied, and placed in the secure emergency box.
- On 6/29/2018, Home patient Face sheets were printed, and placed in the secure emergency box.
- On 6/29/2018, the patient contact information with phone numbers and addresses have been updated and placed in the facility specific emergency plan book.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on/will be delivered by 6/29/2018.

On 6/19/2018, Clinical Manager held Governing Body meeting to go over the updates to the emergency plan. The Governing Body will continue on-going annual review of the Emergency plan and point of contact with the local disaster management team. This will be covered annually in the Quality Assessment Improvement meeting.

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

The Clinical Manager 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 Quality Assessment Improvement 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 Quality Assessment Improvement Committee is responsible to provide oversight, review finders, 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.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

E038

On 6/26/2018, 6/27/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D4 Emergency Patient log

Education emphasis was placed on:

- On 6/26/2018, 6/27/2018 all direct patient care staff and non-direct patient care staff were educated on the Emergency plan policy that went into effect with CMS in November 2017.
- On 6/26/2018, 6/27/2018 all direct patient care staff and non-direct patient care staff were educated and shown the Facility Specific Emergency Plan Book for Caldwell Dialysis, how to use the book, and navigate through the sections, for the specific emergency procedures, policies, and plans.
- Starting on 6/26/2018, the Home Therapies staff and non-direct patient care staff will participate in Fire Drills, disaster planning, table tops, and community drills.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on/will be delivered by 6/29/2018.

On 6/19/2018, Clinical Manager held Governing Body meeting to go over the updates to the emergency plan. The Governing Body will continue on-going annual review of the Emergency plan and point of contact with the local disaster management team. This will be covered annually in the Quality Assessment Improvement meeting.

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

The Clinical Manager 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 Quality Assessment Improvement 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 Quality Assessment Improvement Committee is responsible to provide oversight, review finders, 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.

Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.

Fresenius Medical Care

Dba Caldwell Dialysis

Plan of Correction for

Medicare ESRD Recertification Survey

Date of Survey: 6.15.2018

E039

On 6/26/2018, 6/27/2018, the Clinical Manager held a meeting with all staff and reinforced the expectations and responsibilities of the facility staff on policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D1 Facility Specific Disaster Safety Plan Form

Education emphasis was placed on:

- Ensure all direct patient care and non-direct patient care staff receive training from the Community Drill "Active Shooter".
- On 7/10/2018, Facility will re-hold the Training and drill on the Community Drill "Active Shooter".
- Staff signatures on sign in sheet to verify participation in training and drill. Documentation was placed in the Facility Specific Emergency Book.
- Scheduled on 8/21/2018, 2nd Table Top Drill based on Hazard Vulnerability Assessment. Discussion of Table Top Drill is documented in eQuip for the Quality Assessment Improvement Meeting.
- The Facility Specific Disaster Safety Plan form will be updated with new Table Top and Date.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on/will be delivered by 6/29/2018.

On 6/19/2018, Clinical Manager held a Governing Body meeting to discuss the schedule of the proposed dates for the re-doing of the Top Drill. The Governing Body will continue on-going frequency of the 2 Table Top Drills and the 1 Community Based Drill. This will be discussed in the Quality Assessment Improvement meeting.

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

The Clinical Manager 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 Quality Assessment Improvement 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.

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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.

Clinic Manager is responsible for overall compliance.

The deficiency will be corrected by 7/15/2018.