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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BUREAU OF FACILITY STANDAROS
3232 Elder Street
P.O. Box 83720
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October 3, 2018

Jennifer McMurrian, Administrator
Nampa Dialysis Center
846 Parkcenter Way
Nampa, ID 83651

RE: Nampa Dialysis Center, Provider #132501

Dear Ms. McMurrian:

This is to advise you of the findings of the Medicare survey of Nampa Dialysis Center, which was conducted on September 21, 2018.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **October 16, 2018,** 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

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132501	A. BUILDING _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA DIALYSIS CENTER	848 PARKCENTER WAY NAMPA, ID 83651

(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] The following deficiencies were cited during the recertification survey at your facility from 9/17/18 - 9/21/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: BFR - Blood Flow Rate BP - Blood Pressure c/o - complains of CVC - Central Venous Catheter FA - Facility Administrator IDT - Interdisciplinary Team L - Liter ml - milliliter ml/min - milliliter per minute NC - nasal cannula NS - normal saline O2 - oxygen Pt - patient RB - rinse back (end treatment) RN - Registered Nurse ICHD - Incenter Hemodialysis	V 000	V000 Members of the Governing Body (GB) of Nampa Dialysis have met to review the Statement of Deficiencies (SOD) and formulate the Plan of Correction (POC). The standard level deficiencies under Conditions of Plan of Care Manage Volume Status (V543), Quality Assurance Program Medical Injuries/Errors (V634), Emergency Preparedness Plan Based on All Hazards Risk Assessment (E006), and Information on Occupancy/Needs (E034) that were not met contain specifics of corrective plans. The Governing Body met on 10/11/18 to review POC status. Further compliance to the POC will be reviewed during monthly Facility Health Meeting (FHM) and reported to the Governing Body no less than semi-annually. The Facility administrator (FA) representing the GB will be responsible for ensuring implementation and ongoing compliance with this POC.	10/21/18
V 543	POC-MANAGE VOLUME STATUS CFR(s): 494.90(a)(1) 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 observation, clinical record review,	V 543		

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

Jennifer McMann | RN/FA | 10/15/18

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 543	Continued From page 1 policy review, and staff interview it was determined the facility failed to ensure episodes of hypotension were monitored, addressed, and received appropriate interventions for 1 of 7 ICHD patients (Patient #2) whose treatment records were reviewed. This placed a patient at risk of complications related to hypotension and loss of treatment time. The findings include: During IDT rounds observed on 9/19/18 at 9:00 A.M., Patient #2 told the physician about concerns with her treatment on 9/13/18. She said she had severe leg cramps, saw stars, and vomited. She said this made her afraid to return for her next scheduled treatment. Her treatment sheet for 9/13/18 documented Patient #2's pre treatment blood pressure was 123/57. At 11:00 A.M. Patient #2's BP was 97/69. She took Midodrine (a medication used to increase blood pressure) at that time. At 11:32 A.M. her BP was 98/66. An RN note stated "Goal turned off and 50 ml NS given due to pt c/o cramping." At 11:37 A.M. an RN note stated "BP will not take. Gave extra 50 ml NS. Placed pt on O2 2L NC. Gave Zofran for nausea. Advised patient next step is to RB. Pt only has 12 min. left. Pt requested RB." Patient #2's treatment was terminated at that time. The National Kidney Foundation KDOQI (Kidney Disease Outcome Quelities Initiative) "Clinical Practice Guidelines for Cardiovascular Disease in Dialysis," dated 2005, stated "Intradialytic	V 543	V543 The FA in-serviced 100% of clinical teammates on 10/12/2018 on FluidWise management, communication on the floor, hypotensive episodes and FluidWise focus reporting and on policy 1-03-08 Pre-Intra-Post Treatment Data collection, Monitoring and Nursing Assessment with an emphasis on RN notification of the physician as needed. Evidence of training was accomplished using a training sign in sheet. FA or designee will complete weekly post treatment audits, focusing on response to hypotensive events and falcon intervention from the IDT team. Teammates failing to follow policy and procedure will be counseled. Weekly audits will be completed on 10% of facility patients until 90% compliance is achieved, after which time post treatment audits will be completed monthly as part of the facility's medical record audit. Target compliance 90% documentation in Falcon of fluid management and interventions for hypotensive episodes by IDT team. FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/21/18

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V 543	Continued From page 2 hypotension (IDH) is defined as a decrease in systolic blood pressure by [greater than or equal to] 20 mm Hg ... associated with symptoms that include: abdominal discomfort; yawning; sighing; nausea; vomiting; muscle cramps; restlessness; dizziness or fainting; and anxiety. It impairs the patient's well-being, can induce cardiac arrhythmias, predisposes to coronary and /or cerebral ischemic events. In addition, IDH precludes the delivery of an adequate dose of dialysis, as hypotension episodes lead to compartment effect and result in suboptimal Kt/V." The guidelines further stated "Cardiovascular complications of IDH include: ischemic (cardiac or neurological) events; vascular access thrombosis; dysrhythmias ..." A facility policy 1-09-01 titled Hypotension, revised 10/17, stated the signs and symptoms of hypotension may include, but are not limited to: shortness of breath, nausea and vomiting, pallor, cold or clammy skin, restlessness, sweating, dizziness, decreased mental status, or loss of consciousness. The policy outlined the procedure for patient care staff to follow for hypotension. The procedure included the following: - "Take vital signs. Place patient in a flat supine position." - "Decrease the ultrafiltration rate (UFR) or turn off depending on the patient's condition." - "Administer normal saline bolus of 100-200 ml for severe hypotensive symptoms." - "Administer oxygen per physician order."	V 543		

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V 543	Continued From page 3 - "Continue monitoring blood pressure." - If patient continues to show signs and symptoms of hypotension, notify physician and follow physician's orders. - Document event, orders, treatment and patient response in the patient's medical record. In an interview on 9/21/18 at 10:00 A.M., the FA confirmed facility policy for treatment of hypotension was not followed for Patient #2. She confirmed policy was not followed relative to inadequate saline administration, lack of physician notification, and early treatment termination. The facility failed to ensure Patient #2's volume status was appropriately managed.	V 543		
V 634	QAPI-INDICATOR-MEDICAL INJURIES/ERRORS CFR(s): 494.110(a)(2)(vi) The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on review of records, incident reports, and staff interview, it was determined the facility failed to ensure accurate patient incident data was gathered and analyzed. This failure directly impacted 3 of 7 ICHD patients (Patients #2, #3 and #5) whose records were reviewed and had the potential to impact all patients in the facility. Failure to gather and analyze accurate incident	V 634		

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V 634	Continued From page 4 report information significantly impeded the facility's ability to develop and implement appropriate corrective action plans necessary to minimize the potential for incidents to reoccur. The findings include: 1. Patient #5 was a 60 year old male who dialyzed using a CVC. His dialysis prescription included a BFR to be maintained at 400 ml/min. Ten treatment sheets were reviewed from 7/02/18 - 7/23/18 documenting average BFRs as follows: 7/02/18 - 350 ml/min. 7/04/18 - 284 ml/min. 7/06/18 - 225 ml/min. 7/09/18 - 334 ml/min. On 7/11/18 Patient #5's BFR prescription was decreased to 350 ml/min. BFR was not maintained as follows: 7/13/18 - 262 ml/min. 7/18/18 - 222 ml/min. 7/20/18 - 287 ml/min. 7/23/18 - 325 ml/min. No Incident Reports for treatment errors were available for these occurrences. 2. Patient #3 was an 85 year old male who dialyzed using a CVC. His prescription included a BFR to be maintained at 400ml/min. Six treatment sheets were reviewed from 9/05/18 - 9/17/18 documenting average BFRs as follows: 9/05/18 - 362 ml/min. 9/10/18 - 210 ml/min. 9/12/18 - 240 ml/min.	V 634	V634 The FA in-serviced 100% of clinical teammates on 10/12/2018 on the Adverse Occurrence Reporting (AOR) Policy (non-teammate related) 13-01-02, reviewed what constitutes an AOR, reviewed the process of an AOR, and list of reportable occurrences within the AOR reporting system. The team was also inserviced on policy 1-03-08 Pre-Intra-Post Treatment Data collection, Monitoring and Nursing Assessment with an emphasis on verifying prescription adherence and the steps required when the prescription is not followed, including documentation by the PCT and RN related to prescription nonadherence. Evidence of training was accomplished using a training sign in sheet. The FA or designee will complete weekly post treatment audits, focusing on prescription adherence and documentation when prescription is not followed. Teammates failing to follow policy and procedure will be counseled. Weekly audits will be completed on 10% of facility patients until 90% compliance is achieved, after which time post treatment audits will be completed monthly as part of the facility's medical record audit. Target compliance 90% documentation in Falcon of fluid management and interventions for hypotensive episodes by IDT team. CSS will audit FHM meeting minutes and FHM documentation to ensure AORs are complete, the results of which will be reviewed with the governing body and medical director, until 04/12/2019, after which time AORs will continue to be reviewed in FHM monthly. V634 cont on page 6	10/21/18

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V 634	Continued From page 5 No Incident Reports for treatment errors were available for these occurrences. 3. Patient #2 was a 67 year old female who dialyzed three times a week. During IDT rounds observed on 9/19/18 at 9:00 A.M., Patient #2 told the physician about concerns with her treatment on 9/13/18. She said she had severe leg cramps, saw stars, and vomited. She said this made her afraid to return for her next scheduled treatment. Her treatment sheet for 9/13/18 documented Patient #2's pre treatment blood pressure was 123/57. At 11:00 A.M. Patient #2's BP was 97/69. She took Midodrine (a medication used to increase blood pressure) at that time. At 11:32 A.M. her BP was 98/56. An RN note stated "Goal turned off and 50 ml NS given due to pt c/o cramping." At 11:37 A.M. an RN note stated "BP will not take. Gave extra 50 ml NS. Placed pt on O2 2L NC. Gave Zofran for nausea. Advised patient next step is to RB. Pt only has 12 min. left. Pt requested RB." Patient #2's treatment was terminated at that time. No Incident Report was available for this event. In an interview on 9/21/18 at 10:00 A.M., the FA confirmed BFR had not been consistently maintained for Patients #3 and #5 and Patient #2 did not receive appropriate treatment for severe hypotension. She confirmed incident reports	V 634	V634 Continued from page 5 FA will review results of audits during monthly FHM/governing body meeting with Medical Director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	10/21/18

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V 634	Continued From page 6 should have been completed for the events involving Patients #2, #3, and #5. Adverse events were not appropriately tracked.	V 634		

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E 000	Initial Comments The following Emergency Preparedness deficiencies were cited during the recertification survey at your facility from 9/17/18 - 9/21/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: EP - Emergency Preparedness	E 000	RECEIVED OCT 15 2018 FACILITY STANDARDS	
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.476(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events	E 006	E006 The FA has updated the facility Risk Hazard Analysis to include train car derailment. The Governing Body has reviewed and approved the amended Emergency Plan. The FA will conduct drills for train car derailment with patients and teammates per policy by 11/09/2018. The FA maintains an Emergency Drill schedule and will review the schedule with the Medical Director monthly during the QAPI/Facility Health Meeting. The CSS will audit the facility's Emergency and Disaster Preparedness binder to ensure a facility specific risk assessment and plan is in place, the results of which will he reviewed with the governing body and medical director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	11/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer McManis	RN/FA	10/15/18

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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E 006	Continued From page 1 identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on EP plan review, observation, and staff interview, it was determined the facility failed to develop an EP plan that included a facility specific risk assessment. This failure impacted 40 of 40 incenter patients dialyzing at the facility, 15 of 15 home patients who had frequent appointments at the facility, and all staff employed by the facility by allowing a risk to remain unaddressed in the facility's emergency response plan. The findings include; The facility was located approximately 100 feet away from, and parallel to, two sets of railroad tracks leading into and out of the local train yard. During the survey, loaded freight trains were observed to pass by the facility numerous times each day on their way to and from the train yard to the railroad's main line. A review of the facility's EP plan, on 9/21/18 at 8:00 AM, showed a facility risk assessment identifying several risks including blizzard, wildfire, power failure, and water failure. However, the presence of the railroad operation, that presented the potential of train cars derailing leading to patient injuries, was not identified as a risk to the facility. During an interview on 9/21/18 at 10:00 AM, the FA stated she had not contacted railroad representatives for risk information and had not included the risk in the facility assessment.	E 006		

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E 006	Continued From page 2 The facility failed to ensure a comprehensive facility based, community based risk assessment was performed.	E 006		
E 034	Information on Occupancy/Needs CFR(s): 494.62(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on EP plan review and staff interview, it was determined the facility failed to document a current communication plan for sharing information related to facility needs, and the facility's ability to provide assistance, with	E 034	E034 The FA will develop and maintain and emergency preparedness communication plan that complies with Federal, State and local laws and will be reviewed and updated at least annually and will include the following: A means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. The FA has contacted the local emergency and disaster preparedness liaison, with the Southwest District Health, and the county emergency preparedness and disaster preparedness liaison. The FA will attend a healthcare coalition meeting on 11/15/2018, to address needs during an emergency as well as what assistance we can provide in an emergency. The FA will revise the Emergency Preparedness plan as needed following the meeting if new community hazards are identified and review with the Governing Body for approval. The FA will conduct drills for any newly identified risks and hazards as needed and add them to the drill calendar. The CSS will audit the emergency preparedness communication plan to ensure compliance, results of which will be reviewed with the governing body and medical director. The FA is responsible for the implementation, monitoring and ongoing compliance with this plan of correction.	11/30/18

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132501	A. BUILDING _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA DIALYSIS CENTER	846 PARKCENTER WAY NAMPA, ID 83651

(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
E 034	Continued From page 3 emergency management officials. This deficient practice had the potential to impact all staff and patients at the facility. This failure had the potential to hinder response assistance and continuity of care for patients in the event of an emergency. The findings include: The facility's EP plan was reviewed on 9/21/18 at 8:00 AM. There was no documentation showing the facility had communication with emergency management officials in the community to share information about the facility's needs and the facility's ability to provide assistance in case of emergency. In an interview, at the time of the plan review, the FA stated she had written a letter to county emergency management officials in February, 2018. She said she had no response to the letter and had not shared facility needs and capabilities in the event of an emergency with local emergency planning officials. The facility failed to communicate with local emergency management officials related to potential facility needs or capabilities in case of an emergency.	E 034		