



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0963

February 22, 2011

Victoria Naumann, Administrator
Liberty Dialysis Nampa
280 West Georgia Avenue
Nampa, ID 83686

RE: Liberty Dialysis Nampa, Provider #132516

Dear Ms. Naumann:

Based on the survey completed at Liberty Dialysis Nampa, on February 11, 2011, by our staff, we have determined Liberty Dialysis Nampa is out of compliance with the Medicare ESRD Conditions for Coverage on **CFC-Infection Control (42 CFR 494.30)**, **CFC-Patient Plan of Care (42 CFR 494.90)** and **CFC-QAPI (42 CFR 490.110)**. 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 these conditions to be unmet, substantially limit the capacity of Liberty Dialysis Nampa, 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 Conditions 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

Vicki Bayster, Administrator
February 22, 2011
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- 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 March 28, 2011. 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 March 14, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **March 3, 2011.**

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.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TRISH O'HARA/srm
Enclosures

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

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

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2011
NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST GEORGIA AVENUE NAMPA, ID 83686	
(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 The following deficiencies were cited during the Medicare recertification survey of your ESRD facility. Surveyor conducting the recertification was: Trish O'Hara, R.N., H.F.S. Acronyms used in the report include: AMA - Against Medical Advice BFR - Blood Flow Rate CVC - Central Venous Catheter (used to remove blood from the body for cleaning) EDW - Estimated Dry Weight ESRD - End Stage Renal Disease IDT - Interdisciplinary Team kg - kilogram Kt/V - the measure of dialysis adequacy using dialysis time, blood flow rate, dialysate flow rate, and dialyzer size ml - milliliter POC - Plan of Care QAPI - Quality Assurance Performance Improvement	V 000	This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance: RECEIVED MAR 09 2011 FACILITY STANDARDS	
V 110	494.30 CFC-INFECTION CONTROL This CONDITION is not met as evidenced by: Based on observations, staff interview, and review of policy and procedure, it was determined the facility failed to ensure staff consistently implemented established infection control practices necessary to minimize patients' risk of septicemia infections. This resulted in the risk of infection to patients receiving in-center hemodialysis. The findings include: 1. Refer to V147 as it relates to the facility's	V 110		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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 110 V 147	Continued From page 1 failure to ensure staff adherence to appropriate infection control guidelines for the care of CVCs. 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 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	V 110 V 147	V110,V147 What corrective actions will be implemented to correct the dialysis facility failure to ensure staff consistently implemented established infection control practices necessary to minimize patients' risk of septicemia infections. • Initiate a revised policy and procedure for placement of intravascular catheters in adults and children to reflect manufactures of Alcavis's recommendation for length of time of soak and cleansing ports.	3/7/2011

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V 147	<p>Continued From page 2</p> <p>review of policy and procedure, it was determined the facility failed to ensure staff adequately disinfected CVC ports prior to connecting to and disconnecting from the hemodialysis system, for 4 of 4 patients, (#3, # 5, #7, and #10), whose treatments were observed and who had a CVC in place. This failure exposed patients to intravascular catheter related infections. Findings include:</p> <p>1. The facility's policy, titled "Subclavian/IJ Catheter: Initiation of Dialysis," dated 9/10/2010, directed staff to "place an open sterile 4x4 [gauze] under each extension. Saturate each sterile 4x4 with Betadine or Alcavis 50% [a high level disinfectant]. First scrub each catheter cap, then scrub clamps, then extension tubes and the 'Y' connector. Wrap the end caps with a fresh solution soaked gauze, then wait 5 minutes before continuing."</p> <p>The facility's policy, titled "Subclavian/IJ Catheter: Termination of Dialysis and Post-Dialysis Care," dated 9/10/2010, directed staff to "place an open sterile 4x4 under the catheter. Soak with disinfectant and scrub connections for 2 - 5 minutes."</p> <p>The initiation and termination of dialysis policies were not implemented as follows:</p> <p>a. Patient #3 was a 36 year old male who dialyzed using a CVC. On 2/10/11 at 11:40 A.M. a staff member was observed preparing Patient #3's CVC ports for initiation of dialysis. A gauze soaked in Alcavis, was wrapped around the ports and remained in place for 1 minute. The gauze was then removed and staff opened the CVC ports and connected them to the dialysis blood</p>	V 147	<ul style="list-style-type: none"> o Revised policy and procedure approved by GB 3/1/2011 o Staff in-service on new policy and procedure and skills checklist signed off and educational record placed in personnel folder 3/8/2011 o Divisional Educator scheduled to provide onsite education to all staff on infection control March 8 2011 o Divisional educator will do infection control audit and present findings to Nurse Manager who will present to February's QAPI meeting 	<p>3/8/2011</p> <p>3/8/2011</p> <p>3/8/2011</p>	

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V 147	<p>Continued From page 3</p> <p>lines. At 3:10 P.M., another staff member, who was orienting, was observed disconnecting the CVC ports from the dialysis blood lines at the end of Patient #3's dialysis treatment. The staff member used no disinfecting procedure prior to disconnecting the CVC ports.</p> <p>In an interview on 2/10/11 at 4:00 P.M., the staff member stated she was being trained. The trainer said she thought the ports did not require thorough disinfecting at the end of dialysis because they had not been exposed to germs from outside the facility during the dialysis procedure.</p> <p>b. Patient #5 was a 76 year old male who dialyzed using a CVC. On 2/10/11 at 3:45 P.M., a staff member was observed disconnecting Patient #5's CVC ports from the dialysis blood lines at the end of the dialysis treatment. She wrapped an Alcavis soaked gauze around the port connections and scrubbed the ports for 35 seconds. She then disconnected the CVC ports from the blood lines.</p> <p>In an interview on 2/10/11 at 4:00 P.M., the staff member stated she did not think the ports needed to be thoroughly disinfected at the end of dialysis because they had not been exposed to germs from outside the facility during the dialysis procedure.</p> <p>c. Patient #7 dialyzed using a CVC. On 2/11/11 at 11:15 A.M. a staff member was observed disconnecting Patient #7's CVC ports from the dialysis blood lines at the end of the dialysis treatment. She wrapped an Alcavis soaked gauze around the port connections and secured it with a clamp. The gauze remained clamped in</p>	V 147	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> o Infection control audit will be completed weekly x 4, then monthly. o Infection control audit will be completed by a different staff person each week. Rotated until all staff have done an infection control audit o Results will be reported to Nurse Manager who will then report to the Monthly QAPI meeting and reviewed by Medical Director 	<p>3/4/2011</p> <p>3/24/2011</p>

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V 147	Continued From page 4 place for two minutes. When the patient stood up for a blood pressure check, the gauze fell to the floor and the CVC ports were contaminated by touching a clothing protector. The staff member replaced the gauze with a clean Alcavis soaked gauze. This remained in place for 15 seconds. The staff member then disconnected the CVC ports from the blood lines. d. Patient #10 dialyzed using a CVC vascular access. On 2/10/11 at 11:00 A.M. a staff member was observed initiating Patient #10's dialysis treatment. The staff wrapped an Alcavis soaked gauze around the CVC ports. The gauze remained in place for 55 seconds. Staff then removed the gauze, opened the CVC ports, and connected them to the dialysis blood lines. At 3:30 P.M. on 2/10/11, the same staff member was observed disconnecting Patient #10's CVC ports from the dialysis blood lines at the end of her dialysis treatment. The staff member wrapped an Alcavis soaked gauze around the CVC ports and scrubbed the ports for 1 minute 20 seconds. She then disconnected the CVC ports from the blood lines. In an interview on 2/10/11 at 4:00 P.M., the staff member stated she did not think the ports needed to be thoroughly disinfected at the end of dialysis because they had not been exposed to germs from outside the facility during the dialysis procedure. The facility failed to ensure staff protected patients from infection by adhering to infection control guidelines and facility policy to prevent infection when initiating and terminating dialysis.	V 147	How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: <ul style="list-style-type: none"> o Weekly infection control audit x 4 results reported to Monthly QAPI meeting and reviewed by Medical Director and Nurse Manager o Monthly infection control audits will be reviewed in monthly QAPI meetings by Medical Director o Quarterly infection control audit to be done by Divisional Quality Director and results reported to the Monthly QAPI meeting. Who will be responsible for maintaining correction: <ul style="list-style-type: none"> o Veronica Naumann RN Nurse Manager 	3/3/2011 3/24/2011 4/19/2011
V 540	494.90 CFC-PATIENT PLAN OF CARE	V 540		

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V 540	Continued From page 5	V 540		
V 541	<p>This CONDITION is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure POCs were developed, updated, and implemented to ensure patients were receiving dialysis as prescribed. The cumulative effect of these failures had the potential to result in patients receiving inadequate dialysis. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to V541 as it relates to the facility's failure to ensure POCs were implemented. 2. Refer to V542 as it relates to the facility's failure to ensure a comprehensive POC was developed by the IDT. 3. Refer to V543 as it relates to the facility's failure to ensure POCs adequately addressed volume status. <p>494.90 POC-GOALS=COMMUNITY-BASED STANDARDS</p> <p>The Interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards.</p>	V 541	<p>V540 V541 V542 V543</p> <p>What corrective actions will be implemented to correct the dialysis facility's failure to ensure POCs were developed, updated and implemented to ensure patients were receiving dialysis as prescribed:</p> <ul style="list-style-type: none"> • Initiate a revised POC form that includes review of monthly prescribed blood flow rate, estimated dry weight(EDW) and dialysis time (see attached) • Revised POC form approved by GB 3/7/2011 	3/7/2011

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V 541	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure patients' POCs were implemented to ensure they were provided with their prescribed dose of dialysis, including prescribed BFRs and prescribed dialysis treatment times for 6 of 6 patients, (#1 - #6), whose dialysis prescriptions, dialysis treatment sheets, and POCs were reviewed. This failure had the potential for cumulative inadequate dialysis for patients. Findings include: 1. Patient #5 was a 76 year old male whose hemodialysis prescription ordered a dialysis time of 210 minutes for each treatment and a BFR of 450 ml/minute during each treatment. Patient #5 was observed during the termination of his dialysis treatment on 2/10/11 at 2:30 P.M. Patient #5's machine showed 0:00 time left on the RTD (remaining time to dialyze) clock, which represented the actual elapsed time during a dialysis treatment. At the same time, Patient #5's UF (ultrafiltration) clock showed 2:00 minutes remaining, which represented the time elapsed during which the machine was actually performing waste and fluid removal. Staff discontinued Patient #5's treatment according to the RTD clock rather than the UF clock. Patient #5's treatment was ended early with 2 minutes of dialysis time remaining. Patient #5's treatment sheets were reviewed from 1/1/11 through 2/5/11 and documented prescribed dialysis time and BFR were not attained as follows:	V 541	<ul style="list-style-type: none"> o Staff in-service on new POC 3/8/2011 o Reviewed monthly at the IDT Plan of Care meeting with Physician, Dietitian, MSW, and RN. 3/24/2011 	3/8/2011 3/24/2011

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V 541	<p>Continued From page 7</p> <p>1/1/11 - Time: 198 minutes, BFR:199 1/4/11 - Time: 190 minutes 1/6/11 - BFR: 381 1/8/11 - Time: 198 minutes, BFR: 391 1/11/11 - Time: 205 minutes, BFR: 433 1/13/11 - Time: 208 minutes 1/15/11 - Time: 195 minutes, BFR: 365 1/18/11 - Time: 200 minutes, BFR: 409 1/22/11 - Time: 203 minutes, BFR: 441 1/25/11 - Time: 192 minutes, BFR: 402 1/26/11 - Time: 195 minutes, BFR: 442 1/29/11 - BFR: 392 2/1/11 - BFR: 426 2/3/11 - BFR: 369 2/5/11 - BFR: 412</p> <p>Prescribed time was not attained for 10 of 15 dialysis treatments (representing a cumulative loss of 116 minutes of dialysis in one month) and prescribed BFR was not attained for 13 of 15 dialysis treatments. There was no documentation Patient #5's POC had been updated to address decreased time or BFRs.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #5 did not attain prescribed dialysis time during 67% of reviewed treatments and did not attain prescribed BFR during 86% of reviewed treatments. The Nurse Manager confirmed Patient #5's POC had not been updated to address the decreased treatment time or decreased BFRs.</p> <p>2. Patient #1 was a 68 year old female whose hemodialysis prescription ordered a dialysis time of 240 minutes for each treatment and a BFR of 450 ml/minute during each treatment. Treatment sheets were reviewed from 1/5/11 through 2/4/11 and documented prescribed dialysis time and</p>	V 541	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> ◦ Plan of Care audit will be completed monthly by dietitian to monitor compliance ◦ Results will be reported to Nurse Manager who will then report to the Monthly QAPI meeting and reviewed by Medical Director ◦ Review of EMR Desk audit weekly by Nurse Manager to monitor for any variance in meeting prescribed EDW, BFR, or dialysis time will be completed and reported to monthly Care Plan meeting as well as monthly QAPI 	3/8/2011

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V 541	<p>Continued From page 8 BFR were not attained as follows:</p> <p>1/5/11 - Time: 225 minutes 1/7/11 - Time: 236 minutes, BFR: 396 1/10/11 - Time: 171 minutes, BFR: 398 1/12/11 - BFR: 369 1/14/11 - Time: 169 minutes 1/17/11 - BFR: 372 1/19/11 - Time: 230 minutes 1/21/11 - Time: 238 minutes, BFR: 431 1/24/11 - BFR: 398 1/26/11 - Time: 237 minutes 1/31/11 - BFR: 405 2/2/11 - BFR: 446 2/4/11 - Time: 198 minutes, BFR: 441</p> <p>Prescribed treatment time was not attained during 8 of 13 treatments (representing a cumulative loss of 216 minutes of dialysis during one month) and prescribed BFR was not attained for 9 of 13 dialysis treatments. There was no documentation Patient #1's POC had been updated to address decreased treatment times or BFRs.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #1 did not attain prescribed dialysis time during 69% of reviewed treatments and did not attain prescribed BFR during 62% of reviewed treatments. The Nurse Manager confirmed Patient #1's POC had not been updated to address the decreased treatment time or decreased BFRs.</p> <p>3. Patient #2 was a 59 year old male whose hemodialysis prescription ordered a dialysis time of 195 minutes for each treatment and a BFR of 450 ml/minute during each treatment. Treatment sheets were reviewed from 1/3/11 through 2/7/11 and documented prescribed dialysis time and</p>	V 541	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> o Monthly plan of care audit will be completed by dietitian for completeness of individual POC o Monthly POC audits will be reviewed in monthly QAPI by Medical Director o EMR Desk audit will be reviewed by medical Director in monthly QAPI meeting <p>Compliance date: 3/9/2011</p>	3/24/2011

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(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 541	<p>Continued From page 9</p> <p>BFR were not attained as follows:</p> <p>1/5/11 - BFR: 424 1/7/11 - Time: 182 minutes, BFR: 423 1/10/11 - BFR: 434 1/12/11 - BFR: 446 1/14/11 Time: 193 minutes, BFR: 435 1/17/11 - BFR: 434 1/19/11 - Time: 189 minutes 2/2/11 - Time: 191 minutes</p> <p>Prescribed treatment time was not attained during 4 of 16 treatments (representing a cumulative loss of 25 minutes of dialysis during one month) and prescribed BFR was not attained for 6 of 16 dialysis treatments. There was no documentation Patient #2's POC had been updated to address decreased treatment times or BFRs.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #2 did not attain prescribed dialysis time during 25% of reviewed treatments and did not attain prescribed BFR during 37.5% of reviewed treatments. The Nurse Manager confirmed Patient #2's POC had not been updated to address the decreased treatment time or decreased BFRs.</p> <p>4. Patient #3 was a 36 year old male whose hemodialysis prescription ordered a dialysis time of 240 minutes for each treatment and a BFR of 450 ml/minute during each treatment. Treatment sheets were reviewed from 1/20/11 through 2/5/11 and documented prescribed dialysis time and BFR were not attained as follows:</p> <p>1/22/11 - BFR: 391 1/25/11 - Time: 226 minutes, BFR: 400 1/27/11 - BFR: 387</p>	V 541	<p>Who will be responsible for maintaining correction:</p> <ul style="list-style-type: none"> o Veronica Naumann RN Nurse Manager 	

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V 541	<p>Continued From page 10</p> <p>1/29/11 - BFR: 384 2/1/11 - BFR: 384 2/4/11 - BFR: 403 2/5/11 - BFR: 360</p> <p>Prescribed treatment time was not attained during 1 of 8 treatments (representing a cumulative loss of 14 minutes of dialysis during a 3 week period) and prescribed BFR was not attained for 7 of 8 dialysis treatments. There was no documentation Patient #3's POC had been updated to address decreased treatment times or BFRs.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #3 did not attain prescribed dialysis time during 12.5% of reviewed treatments and did not attain prescribed BFR during 87.5% of reviewed treatments. The Nurse Manager confirmed Patient #3's POC had not been updated to address the decreased treatment time or decreased BFRs.</p> <p>5. Patient #4 was a 76 year old female whose hemodialysis prescription ordered prescription ordered a dialysis time of 210 minutes for each treatment and a BFR of 400 ml/minute during each treatment. Treatment sheets were reviewed from 1/4/11 through 2/5/11 and documented prescribed dialysis time and BFR were not attained as follows:</p> <p>1/8/11 - BFR: 395 1/13/11 - Time: 205 minutes 1/15/11 - Time: 208 minutes 1/18/11 - BFR: 393 1/20/11 - BFR: 391 1/25/11 - Time: 204 minutes 2/1/11 - Time: 209 minutes, BFR: 392 2/3/11 - Time: 194 minutes</p>	V 541		

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V 541	<p>Continued From page 11 2/5/11 - Time: 206 minutes</p> <p>Prescribed treatment time was not attained during 6 of 13 treatments (representing a cumulative loss of 34 minutes of dialysis during one month) and prescribed BFR was not attained for 4 of 13 dialysis treatments. There was no documentation Patient #4's POC had been updated to address decreased treatment times or BFRs.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #4 did not attain prescribed dialysis time during 46% of reviewed treatments and did not attain prescribed BFR during 31% of reviewed treatments. The Nurse Manager confirmed Patient #4's POC had not been updated to address the decreased treatment time or decreased BFRs.</p> <p>6. Patient #6 was a 78 year old male whose hemodialysis prescription ordered a dialysis time of 240 minutes during each treatment and a BFR of 450 ml/minute during each treatment. Treatment sheets were reviewed from 1/3/11 through 2/4/11 and documented prescribed dialysis time and BFR were not attained as follows:</p> <p>1/3/11 - Time: 230 minutes, BFR: 421 1/5/11 - Time: 200 minutes, BFR: 449 1/7/11 - BFR: 449 1/12/11 - BFR: 401 1/14/11 - BFR: 438</p> <p>Patient #5 was hospitalized 1/19/11 - 1/26/11. No treatment sheets were available from that time period for review.</p> <p>1/28/11 - BFR: 351</p>	V 541			

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V 541	Continued From page 12 1/31/11 - Time: 236 minutes, BFR: 400 2/2/11 - BFR: 390 2/4/11 - Time: 237 minutes, BFR: 388 Prescribed treatment time was not attained during 4 of 10 treatments (representing a cumulative loss of 57 minutes of dialysis during one month) and prescribed BFR was not attained for 9 of 10 dialysis treatments. There was no documentation Patient #6's POC had been updated to address decreased treatment times or BFRs. In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #6 did not attain prescribed dialysis time during 40% of reviewed treatments and did not attain prescribed BFR during 90% of reviewed treatments. The Nurse Manager confirmed Patient #6's POC had not been updated to address the decreased treatment time or decreased BFRs. Additionally, in an Interview on 2/10/11 at 8:00 A.M., the facility's Medical Director confirmed Patients #1 - #6 had received dialysis treatments inconsistent with their POCs, based on decreased BFRs and decreased dialysis times. The facility failed to ensure patients' POC were implemented to ensure they received their prescribed dose of dialysis.	V 541			
V 542	494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure the IDT developed an effective plan of care for 1 of 6	V 542			

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V 542	Continued From page 13 patients, (#3), whose plans of care were reviewed. This failure created the potential for inadequate dialysis of patients. Findings include: 1. Patient #3 was a 36 year old male who began chronic dialysis treatments at the facility on 1/20/11. His POC, dated 1/25/11 and signed by IDT members, documented his adequacy as 1.16 Kt/V. This was verified by laboratory values obtained on 1/20/11. Additional adequacy lab values, obtained 1/25/11, showed Patient #3's Kt/V as 1.15. Minimum standard Kt/V was documented as being 1.20. The Plan/Intervention portion of the POC contained no interventions to increase Patient #3's dialysis adequacy. A note was made stating "going to PD...". In an interview on 2/9/11 at 9:15 A.M. the Nurse Manager confirmed the POC did not document interventions to increase Patient #3's adequacy of dialysis. The facility failed to ensure Patient #3's POC included interventions to improve his quality of dialysis.	V 542		
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The Interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure POCs were updated with measures to manage volume status for 4 of 6 patients, (#1, #4, #5, and #6), whose hemodialysis prescription orders, dialysis	V 543		

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V 543	<p>Continued From page 14</p> <p>treatment sheets, and POCs were reviewed. This failure created the potential for inadequate removal of fluid and adverse effects of fluid accumulation for patients. Findings include:</p> <p>1. Patient #1 was a 68 year old female who had been receiving dialysis treatments at the facility since admission on 11/29/08. Review of Patient #1's hemodialysis orders showed her prescribed EDW as 129 kg. Treatment sheets from 1/5/11 through 2/4/11 showed she had not attained prescribed EDW during 14 of 14 dialysis treatments. The following post dialysis weights were documented:</p> <p>1/5/11: 129.7 kg 1/7/11: 129.4 kg 1/10/11: 132.0 kg 1/12/11: 132.1 kg 1/14/11: 131.9 kg 1/17/11: 133.0 kg 1/19/11: 133.2 kg 1/21/11: 133.3 kg 1/24/11: 132.3 kg 1/26/11: 131.9 kg 1/31/11: 132.8 kg 2/2/11: 131.5 kg 2/4/11: 130.1 kg</p> <p>There was no documentation Patient #1's POC had been updated to address volume status.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #1 had not attained EDW during 100% of the treatments reviewed and confirmed the lack of POC update.</p> <p>2. Patient #4 was a 76 year old female who had been dialyzing at the facility since admission on</p>	V 543			

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V 543	<p>Continued From page 15</p> <p>10/14/08, Review of Patient #4's hemodialysis orders showed her prescribed EDW as 88 kg prior to 1/25/11 and 88.5 kg from 1/26/11 forward. Treatment sheets from 1/4/11 through 2/5/11 showed she had not attained prescribed EDW during 13 of 13 dialysis treatments. The following post dialysis weights were documented:</p> <p>EDW 88 kg 1/4/11: 88.5 kg 1/8/11: 89.6 kg 1/11/11: 88.8 kg 1/13/11: 89.3 kg 1/15/11: 88.4 kg 1/18/11: 88.8 kg 1/20/11: 89.0 kg</p> <p>EDW 88.5 kg 1/26/11: 90.5 kg 1/27/11: 89.7 kg 1/29/11: 89.3 kg 2/1/11: 89.8 kg 2/3/11: 89.2 kg 2/5/11: 89.4 kg</p> <p>There was no documentation Patient #4's POC had been updated to address her continued failure to attain prescribed EDW.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #4 had not attained EDW during 100% of the treatments reviewed and confirmed the lack of POC update.</p> <p>3. Patient #5 was a 76 year old male who had been receiving dialysis treatments at the facility since admission on 7/27/10. Review of Patient #5's hemodialysis orders showed his prescribed EDW as 59 kg prior to 1/26/11 and 59.5 kg from</p>	V 543		

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V 543	<p>Continued From page 16</p> <p>1/26/11 forward. Treatment sheets from 1/1/11 through 2/5/11 were reviewed and showed he had not attained prescribed EDW during 10 of 15 dialysis treatments. The following post dialysis weights were documented:</p> <p>EDW 59 kg 1/4/11: 59.2 kg 1/11/11: 59.4 kg 1/18/11: 59.2 kg 1/22/11: 60.0 kg 1/25/11: 60.3 kg</p> <p>EDW 59.5 kg 1/26/11: 60.3 kg 1/29/11: 60.4 kg 2/1/11: 61.0 kg 2/3/11: 60.1 kg 2/5/11: 59.9 kg</p> <p>There was no documentation Patient #5's POC had been updated to address his continued failure to attain prescribed EDW.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #5 had failed to attain EDW during 66% of the treatments reviewed and confirmed the lack of POC update.</p> <p>4. Patient #6 was a 78 year old male who had been receiving dialysis treatments at the facility since his admission on 6/28/10. Patient #6 had a comorbid health condition that caused ascites (the collection of fluid in the abdominal cavity). He received paracentesis (removal of the abdominal fluid) treatments on a monthly basis, at another health care facility, with the most recent paracentesis being performed on 1/13/11.</p>	V 543			

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V 543	<p>Continued From page 17</p> <p>Review of Patient #6's hemodialysis order showed his prescribed EDW as 76 kg. Treatment sheets from 1/3/11 through 2/4/11 were reviewed and showed he had not attained EDW during 9 of 10 dialysis treatments. The following post dialysis weights were documented:</p> <p>1/3/11: 76.6 kg 1/5/11: 76.7 kg 1/7/11: 76.5 kg 1/10/11: 77.2 kg 1/12/11: 77.7 kg</p> <p>1/19/11 - 1/26/11: Patient #6 was hospitalized and did not receive treatment from the facility.</p> <p>1/28/11: 79.0 kg 1/31/11: 80.4 kg 2/2/11: 79.3 kg 2/4/11: 79.1 kg</p> <p>There was no documentation Patient #6's POC had been updated to address volume status.</p> <p>In an interview on 2/9/11 at 9:00 A.M., the Nurse Manager confirmed Patient #6 had failed to attain EDW during 90% of treatments reviewed, and confirmed the lack of POC update addressing volume status. She stated Patient #6's EDW was not attained because nursing staff was unable to distinguish between fluid gained due to ESRD and fluid gained due to ascites.</p> <p>Additionally, in an interview on 2/10/11 at 8:00 A.M., the facility's Medical Director confirmed Patients #1, #2, #4, and #6 had consistently failed to attain their prescribed EDWs.</p> <p>The facility failed to ensure care was given to</p>	V 543			

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V 543 V 625	Continued From page 18 manage patients' volume status. 494.110 CFC-QAPI	V 543 V 625			
V 634	<p>This CONDITION is not met as evidenced by: Based on staff interview and QAPI meeting minutes review, it was determined the facility failed to ensure an effective QAPI program was maintained that recognized and corrected problems affecting patients' health. This failure had the potential to decrease the quality of treatment received by patients. Findings include:</p> <p>Refer to V634 as it relates to the facility's failure to ensure the QAPI program tracked, analyzed, corrected, and monitored the delivery of prescribed dialysis doses, to ensure patients received prescribed dialysis treatments.</p> <p>494.110(a)(2)(vi) QAPI-INDICATOR-MEDICAL INJURIES/ERRORS</p> <p>The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and QAPI meeting minutes review, it was determined the facility failed to ensure the QAPI program collected and analyzed data, and instituted and monitored a corrective plan for medical errors, including incorrect dialysis doses for 6 of 6 patients, (#1 - #6), whose dialysis prescriptions, dialysis treatment sheets, and POCs were reviewed. This failure had the potential of patients being adversely affected by the occurrence of avoidable</p>	V 634	<p>What corrective actions will be implemented to correct the dialysis facility's failure to ensure the QAPI program collected and analyzed data and instituted and monitored a corrective plan for medical errors:</p> <ul style="list-style-type: none"> The EMR desk audit variance has been changed to highlight 0% variance instead of only 10% variance to be reviewed weekly by Nurse Manager and presented to monthly POC meeting and QAPI 	3/1/2011	

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V 634	Continued From page 19 medical errors. Findings include: 1. QAPI meeting minutes for 7/2010 through 12/2010 were reviewed with the Nurse Manager on 2/9/11 at 9:00 A.M. The Nurse Manager presented additional tools that were used by the facility to collect data for the QAPI program. These included a form titled "In-Center Adverse Event Record Tool," and a desk audit. a. The "In-Center Adverse Event Record Tool" collected data that included the number of AMA occurrences for each month. The Nurse Manager explained patients were asked to sign an AMA form if it was their desire to end their dialysis treatment more than 15 minutes early. This limitation excluded treatments that ended 1 - 14 minutes early, allowing for a potentially significant unreported loss of dialysis time. It also excluded the reporting of dialysis treatments shortened for any reason other than patient preference. b. The desk audit was a software program available to the Nurse Manager on a desk top computer. The audit documented a detailed review of all patient treatments performed by facility staff. In an interview on 2/9 11 at 9:00 A.M., the Nurse Manager stated she reviewed the audit on a weekly basis. She said the reporting of irregularities in patient treatments found on the desk audit, to the IDT, was left to her judgement. Further examination of the desk audit showed the presence of an allowed 10% variance for BFRs and dialysis treatment times. A 1 kg. variance was allowed for EDW. These variances allowed significant deficits in patient BFRs, treatment times, and attained EDWs to remain unreported. Patients who did not receive their prescribed	V 634	<ul style="list-style-type: none"> o EDW protocol written and approved by Governing Body March 2, 2011 o Staff in serviced on new EDW protocol 3/8/2011 o Reviewed monthly at the IDT Plan of Care meeting with Physician, Dietitian, MSW, and RN. 	 3/2/2011 3/8/2011 3/24/2011	

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NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 280 WEST GEORGIA AVENUE NAMPA, ID 83686	
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V 634	<p>Continued From page 20</p> <p>dialysis treatments were not adequately identified resulting in patients not attaining their EDWs, a cumulative loss of dialysis times and decreased BFRs as follows:</p> <ul style="list-style-type: none"> - Patient 5's treatment sheets were reviewed from 1/1/11 through 2/5/11. He did not meet his EDW in 66% of the treatments reviewed, did not attain prescribed dialysis time during 67% of the treatments reviewed, and did not attain prescribed BFR during 86% of the treatments reviewed. - Patient #1's treatment sheets were reviewed from 1/5/11 through 2/4/11. She did not meet her EDW during 100% of the treatments reviewed, did not attain prescribed dialysis time during 69% of the treatments reviewed, and did not attain prescribed BFR during 62% of the treatments reviewed. - Patient #4's treatment sheets were reviewed from 1/4/11 through 2/5/11. She did not meet her EDW during 100% of the treatments reviewed, did not attain prescribed dialysis time during 46% of the treatments reviewed, and did not attain prescribed BFR during 31% of the treatments reviewed. - Patient #6's treatment sheets were reviewed from 1/3/11 through 2/4/11. He did not meet his EDW in 90% of the treatments reviewed, did not attain prescribed dialysis time during 40% of the treatments reviewed, and did not attain prescribed BFR during 90% of the treatments reviewed. - Patient #2's treatment sheets were reviewed from 1/3/11 through 2/7/11. He did not attain his 	V 634	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> o EMR desk audit will be completed weekly by Nurse Manager to monitor compliance o Results will be reported to Monthly QAPI meeting and reviewed by Medical Director and to the Monthly IDT POC meeting and reviewed by Physician 	3/24/2011

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132516	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2011	
NAME OF PROVIDER OR SUPPLIER LIBERTY DIALYSIS NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 280 WEST GEORGIA AVENUE NAMPA, ID 83686		
(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 634	<p>Continued From page 21</p> <p>prescribed dialysis time during 25% of the treatments reviewed and did not attain his prescribed BFR during 37.5% of the treatments reviewed.</p> <p>- Patient #3's treatment sheets were reviewed from 1/20/11 through 2/5/11. He did not attain prescribed dialysis time during 12.5% of the treatments reviewed and did not attain his prescribed BFR during 87.5% of the treatments reviewed.</p> <p>In an interview on 2/9/11 at 9:15 A.M., the Nurse Manager confirmed the desk audit, and ultimately the QAPI program, failed to identify consistent deficits in patient dialysis treatments.</p> <p>In an interview on 2/10/11 at 8:00 A.M., the Medical Director confirmed the desk audit, and ultimately the QAPI program, failed to identify consistent deficits in patient dialysis treatments.</p> <p>The facility failed to measure, analyze and track quality indicators that influenced patient outcomes.</p>	V 634	<p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> o Weekly EMR desk audit will be completed by Nurse Manager o EMR Desk audit will be reviewed by medical Director in monthly QAPI meeting and monthly in POC IDT meeting by physician <p>Compliance date: 3/9//2011</p> <p>Who will be responsible for maintaining correction:</p> <ul style="list-style-type: none"> o Veronica Naumann RN Nurse Manager 	

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