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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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PHONE 208-334-6626
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April 6, 2012

Larry Kelley, Administrator
Burley Dialysis Center
741 North Overland Avenue
Burley, ID 83318-2106

RE: Burley Dialysis Center, Provider #132503

Dear Mr. Kelley:

This is to advise you of the findings of the Medicare survey of Burley Dialysis Center, which was conducted on March 29, 2012.

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:

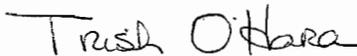
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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.

Larry Kelley, Administrator
April 6, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **April 18, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



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



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm
Enclosures

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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132503	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2012
NAME OF PROVIDER OR SUPPLIER BURLEY DIALYSIS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 741 NORTH OVERLAND AVENUE BURLEY, ID 83318	
(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)
V 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the recertification survey was:</p> <p>Trish O'Hara, R.N., H.F.S.</p> <p>Acronyms used in this report include:</p> <p>AV - Arterio-venous CVC - Central Venous Catheter kg - kilogram (2.2 pounds) L - Liter (1000 ml or 33.3 ounces) mEq/L - milliequivalent/Liter (measure of concentration) ml - milliliter (30 ml = 1 ounce) PCT - Patient Care Technician PD - Peritoneal Dialysis RN - Registered Nurse RO - Reverse Osmosis</p>	V 000	<p style="text-align: center;">RECEIVED APR 23 2012 FACILITY STANDARDS</p>
V 112	<p>494.30(a) IC-CDC MMWR 2001</p> <p>The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource</p>	V 112	<p>V 112 Teammates will be educated on infection control to include but not limited to access hygiene. FA will review Procedure 1-04-01A AV Fistula or Graft Cannulation with Safety Needles with all patient care teammates with emphasis on step 2: "Have patient wash access site with appropriate antibacterial soap, if able." All but one handwashing posters will be removed from the patient education wall by the patient educator to reduce/eliminate clutter and enhance the educational environment for infection control.</p> <p style="text-align: right;">4/2/12</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Larry T. Geller* TITLE: *RN, FA, Facility Admin.* (X6) DATE: *4-20-12*

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 112	<p>Continued From page 1</p> <p>Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html.</p> <p>The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide infection control precautions for 3 of 6 patients (Patients #6 - #8) whose dialysis treatment initiation was observed using upper extremity accesses. This failure created the potential for access infections. Findings include:</p> <p>KDOQI guidelines for infection control state, "wash access site using an antibacterial soap or scrub and water; cleanse the skin by applying 70% alcohol and/or 10% povidone iodine using a circular rubbing motion."</p> <p>On 3/28/12 at 2:30 PM, the patient educator provided the surveyor with the monthly topics for patient education that had been addressed over the past year. Handwashing and access</p>	V 112	<p>All patients will be questioned by the teammates as they arrive at their chair to ensure proper washing of their accesses.</p> <p>For patients that have not or can not wash their access, the teammate will wash or assist the patient to wash their access.</p> <p>The RN Infection Control Manager will monitor compliance with access washing during monthly IC audit. This is reported in the CQI meeting to insure corrections are sustained.</p>	4/17/12

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V 112	<p>Continued From page 2</p> <p>extremity washing were included in this patient education.</p> <p>During observations on 3/28/12 from 9:45 - 11:15 AM it was noted there were 5 notices posted in the patient preparation area reminding patients to wash their hands prior to treatment. There was 1 notice posted reminding patients to wash their access extremity prior to treatment.</p> <p>During observations on 3/28/12 from 9:45 - 11:15 AM, six patients did not wash their access extremity at the sink provided in the patient preparation area. Of these 6 patients, three patients were questioned by staff at the chairside about access extremity washing and were assisted with this task if needed. Patients #6, #7, and #8 were not questioned by staff about access extremity washing, or assisted with the task, prior to the initiation of dialysis.</p> <p>In an interview on 3/27/12 at 11:00 AM, the facility administrator said it was facility policy that all patients wash their access extremity prior to the initiation of dialysis treatment.</p> <p>The facility failed to maintain a comprehensive infection control program.</p>	V 112	
V 245	<p>494.40(a) ACID CONC DIST-CONC LABELED & COLOR-CODED RED</p> <p>5.5.3 Acid concentrate distribution systems: labeled & color-coded red Acid concentrate delivery piping should be labeled and color-coded red at the point of use (at the jug filling station or the dialysis machine connection).</p>	V 245	<p>V245 Acid concentrate labels will be changed by the Biomed teammate on all dialysate delivery ports to reflect current composition and to insure the use of correct dialysis concentration to prevent adverse effects to the patients.</p>

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V 245	<p>Continued From page 3</p> <p>All joints should be sealed to prevent leakage of concentrate. If the acid system remains intact, no rinsing or disinfection is necessary.</p> <p>More than one type of acid concentrate may be delivered, and each line should clearly indicate the type of acid concentrate it contains.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to provide appropriate labeling for acid concentration at the point of delivery. This failure had the potential to adversely affect all patients receiving dialysis treatments at the facility through the use of incorrect dialysate concentration. Findings include:</p> <p>The facility mixed liquid acid concentrate from powder form, using RO water, and stored the liquid product in large tanks in the water treatment room. The product was then pumped from the tanks to the dialysis machines on the treatment floor through a piping system.</p> <p>During a tour of the water treatment room on 3/27/12, it was observed that one tank was marked 2K/2.0Ca and a second tank was marked 3K/2.0Ca. According to the labels affixed to the tanks, this indicated the Acid concentrations contained Potassium 2 mEq/L and Calcium 2.0 mEq/L, and Potassium 3 mEq/L and Calcium 2.0 mEq/L.</p> <p>During a tour of the facility treatment floor on 3/28/12, it was observed that the acid concentrate outlets for each dialysis machine were labeled 2K/2.5Ca and 3K/2.5Ca respectively, indicating</p>	V 245	<p>Containers used for "1.0K, 2.25Ca dialysate delivery to the patient will be properly labeled. FA will review Policy 4-04-05 Labeling of Containers and Policy 2-04-05 Acid Concentrate System, Incoming Acid Concentrate and supply log and use of Acid Gallon Concentrate Containers with teammates.</p> <p>Proper labelling of containers and dialysate delivery ports will be monitored by the FA during monthly FA audits and by the Biomed teammate during monthly Biomed audits.</p>	4/17/12

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V 245	Continued From page 4 the acid concentrations being delivered contained 2 mEq/L of Potassium and 2.5 mEq/L of calcium, and 3 mEq/L of Potassium and 2.5 mEq/L of Calcium respectively. In an interview on 3/26/12 at 3:00 PM, the facility administrator said the facility medical director had changed all acid concentrations for patient prescriptions to include a Calcium content of 2.0 mEq/L sometime in the past. In an interview on 3/28/12 at 4:00 PM, the facility water technician acknowledged this change and said a request had been made for relabeling of the acid concentration outlets about a year ago but it had not been done. Additionally, during a tour of the facility storage area there were three large jugs marked 1K, indicating 1 mEq/L Potassium. The labels did not indicate a Calcium concentration of the liquid contained in the jugs. In an interview on 3/27/12 at 9:00 AM, the facility biomedical technician said these jugs had been filled from a blue 55 gallon drum located in the water treatment area. The drum was labeled to indicate the contents had a Potassium concentration of 1 mEq/L and a Calcium concentration of 2.25 mEq/L. The facility failed to label the correct acid concentration present at the delivery point.	V 245		
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to-	V 463	V 463 The patient treatment prescription will be monitored by the Charge Nurse of each patient on each shift during the charge nurse daily audit to ensure that patients receive correct dialysis treatments.	

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V 463	<p>Continued From page 5</p> <p>(12) Receive the necessary services outlined in the patient plan of care described in §494.90;</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to deliver dialysis treatments as ordered by the physician for 2 of 3 patients (Patient #1 and #2) whose hemodialysis treatments were reviewed. Findings include:</p> <p>a. Patient #1 was a 72 year old female who had been dialyzing at the facility since 2/3/10. Her prescription ordered hemodialysis 3 times a week for 195 minutes, using 15 gauge needles. It further ordered a blood flow rate of 425 ml/minute and a dialysate flow rate of 700 ml/ minute. Her dry weight was prescribed to be 109.5 kg.</p> <p>Ten treatments were reviewed for Patient #1, from 3/5 - 3/26/12, with the following results.</p> <p>- On 3/5/12 a blood flow rate of 405 ml/minute was recorded for 1.5 hours. There was no documentation explaining why a decreased blood flow rate was used.</p> <p>- On 3/9/12 a blood flow rate of 410 ml/minute was recorded for the entire run due to high arterial pressure. There was no documentation indicating the cause of the high arterial pressure was investigated, corrected, or reported.</p> <p>- On 3/12/12 a pre dialysis weight was recorded as 109.8 kg and the dialysis machine recorded a 1.8 L fluid removal. A post dialysis weight was recorded as 110.9 kg, 1.1 kg more than her pre</p>	V 463	<p>Variations to the dialysis treatment will be corrected immediately and documented in the treatment flow sheet. Unresolvable variations will have rationale documented, and the MD will be notified by the charge nurse for follow-up.</p> <p>FA will review Policy 3-02-02, Medical Record Preparation and Charting Guidelines & 1-03-09 Intradialytic Treatment Monitoring, with TMs.</p> <p>CSS will complete 4 PTR audits weekly for 1 month and report to FA. FA is responsible for seeing that correction is sustained. Results of audits will be reported to QIFMM.</p>	4/2/12

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V 463	<p>Continued From page 6</p> <p>dialysis weight. There was no documentation the weight discrepancy was investigated or extra ultrafiltration time was offered to the patient. The patient presented for her 3/14/12 dialysis treatment weighing 113.9 kg.</p> <ul style="list-style-type: none"> - On 3/21/12 a blood flow rate of 400 ml/minute was recorded for the entire treatment. No documentation was present to explain why a decreased blood flow rate was used. - On 3/23/12 a blood flow rate of 200 ml/minute was recorded for the first 30 minutes of treatment. There was no documentation present indicating why a decreased blood flow rate was used <p>In an interview on 3/27/12 from 3:30 - 6:30 PM, the facility administrator confirmed Individual #1's prescribed dialysis treatment was not administered, and that there was no documentation indicating why blood flows were decreased and dry weight was not attained.</p> <p>b. Patient #2 was a 61 year old female who had been dialyzing at the facility since 12/2/11. Her prescription ordered hemodialysis 3 times a week for 150 minutes with a blood flow rate of 400 ml/minute and a dialysate flow rate of 600 ml/minute. Her dry weight was prescribed to be 43 kg.</p> <p>In an interview on 3/27/12 at 4:00 PM, the facility administrator explained that Patient #2 was transitioning from the use of a CVC access to the use of an AV fistula during this time period. This process, indicated in a facility policy titled "Cathaway," dated 2008, entailed the use of</p>	V 463		
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V 463	<p>Continued From page 7</p> <p>progressively larger needle sizes to be used at specified intervals, as the A/V fistula matured.</p> <p>Ten treatments were reviewed for Patient #2, from 3/5 - 3/26/12, with the following results:</p> <ul style="list-style-type: none"> - On 3/5/12 there was no documentation indicating what size needle was to be used or what size needle was actually used for treatment. - On 3/7/12 there was no documentation indicating what size needle was to be used or what size needle was actually used for treatment. - On 3/9/12 there was no documentation indicating what size needle was to be used or what size needle was actually used for treatment. Additionally, a blood flow rate of 300 ml/minute was recorded. No documentation was present to explain why a decreased blood flow rate was used. - On 3/12/12 there was no documentation indicating what size needle was to be used or what size needle was actually used for treatment. - On 3/14/12 there was no documentation indicating what size needle was to be used or what size needle was actually used for treatment. - On 3/21/12 a blood flow rate of 350 ml/minute and a dialysate flow rate of 800 ml/minute was recorded. No documentation was present to explain why a decreased blood flow rate and an increased dialysate flow rate was used. <p>In an interview on 3/27/12 from 3:30 - 6:30 PM, the facility administrator confirmed Individual #2's</p>	V 463		
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V 587	Continued From page 9 In an interview on 3/27/12 at 9:00 AM, the facility's home dialy patient had not sub above for review, d the flow sheets. W not documented th flow sheets.	V 587		
V 681	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions. This STANDARD is not met as evidenced by: Based on personnel record review and staff interview it was determined the facility failed to document demonstrated competencies for 4 of 6 direct care staff (Staff #1 - #4) whose personnel records were reviewed. Findings include: Personnel records were reviewed for six direct care staff. Two staff had initiated employment during the last year and had current skill competency checks in their files. Four direct care	V 681	V 681 Competency review will be completed for the clinical teammates by the facility preceptor on an annual basis to insure the teammates meet the facility competency standard to ensure the comprehensive needs of the patients are met and teammates perform specific duties of their position per policy. Annual Verification of Competency form will be stored in the teammate file and maintained by the FA. FA is responsible for ensuring this is done and evidence of completion will be monitored by the FA during quarterly teammate file audits.	4/17/12

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V 681	<p>Continued From page 10 staff, including 2 RNs and 2 PCTs had documentation of the most recent competency testing dated 10/2010.</p> <p>In an interview on 3/29/12 at 11:00 AM, the facility administrator stated that it was the facility's policy to perform and document annual competency checks for all direct care staff. He stated this had been done "a few months ago" but he was unable to locate the documentation.</p> <p>The facility failed to document direct care staffs' ability to perform the specific duties of their positions.</p>	V 681			