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
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PHONE 208-334-6626
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November 22, 2011

Brandy Leaming, Administrator
Liberty Dialysis Hayden
8556 Wayne Drive
Hayden, ID 83835

RE: Liberty Dialysis Hayden, Provider #132519

Dear Ms. Leaming:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Hayden, which was conducted on November 9, 2011.

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 **December 4, 2011,** 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

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: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	132519		11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS HAYDEN	8556 WAYNE DRIVE HAYDEN, ID 83835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
V 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the recertification survey was: Trish O'Hara, R.N., H.F.S. Acronyms used in the report include: CDC - Center for Disease Control CVC - Central Venous Catheter IV - Intravenous PPE - Personal Protective Equipment	V 000	RECEIVED DEC 05 2011 FACILITY STANDARDS	
V 117	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients.	V 117	494.30 V117 Medication preparation area located on existing, immoble counter identified by the Nurse Manager and clearly designated with signage. Area segregated by barrier installed by BioMedical Technician to separate clean areas from contaminated in order to provide a centralized location for the preparation of individual patient doses away from dialysis stations or where used equipment or blood samples are handled.	Thursday 11-10-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RM Cm | (X6) DATE 12-1-2011

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 117	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure a designated area was provided for the preparation of medications. This failure directly impacted 4 of 4 patients (#1,#2,#3, and #5) receiving Heparin, whose care was observed, and had the potential to expose all incenter hemodialysis patients, whose treatment orders included the use of Heparin, to contamination by infectious and chemical agents. Findings include: During patient care observations on 11/3/11 from 12:00 - 2:00 PM, two moveable supply carts, measuring approximately 24 inches by 24 inches, were noted to be in the treatment area. These carts contained clean supplies including gauze, fistula needles, disinfecting solution for CVC ports, empty syringes and several multiple dose vials of Heparin (a medication used in IV form to prevent blood from clotting). The surface of the carts were covered with disposable paper covers that were stained with CVC port disinfecting solution. Three direct care staff members were observed accessing supplies from these carts. In an interview on 11/3/11 from 12:30 - 1:00 PM, one direct care staff stated Heparin syringes had been prepared on the supply carts for at least two years. In an interview on 11/3/11 at 5:00 PM, the facility's nurse manager confirmed the location of the Heparin preparation area on the supply carts, and stated there was insufficient room at the nurse station medication preparation area to accommodate all the staff members who prepared Heparin for their individual patients. She further stated it was located on the treatment floor to discourage staff from wearing PPE into	V 117	All Direct Patient Care (DPC) staff educated on the use of the medication station and appropriate disinfection of counter prior to medication preparation by the Nurse Manager or designee. Nurse Manager or designee will audit new medication preparation area usage for 2 weeks and provide reinforcement as needed Nurse Manager will include proper use of Medication Preparation area to Infection Control audit. Audit will be completed by designated staff member monthly.	Thursday 11-10-2011 Thursday 11-24-2011 Thursday 11-10-2011

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V 117	Continued From page 2 the clean area of the nurse station. The facility failed to provide a clean area for Heparin syringe preparation that was dedicated to medication preparation only.	V 117		
V 416	494.60(d)(4)(iii) PE-CONTACT LOCAL EOC ANNUALLY The facility must- (iii) Contact its local disaster management agency at least annually to ensure that such agency is aware of dialysis facility needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure patient safety, in the event of an emergency or disaster, by making patient needs known to the local disaster management agency. This failure had the potential to negatively impact all patients receiving dialysis services at the facility, with inadequate community response in the case of emergency or disaster. Findings include: During review of the facility's emergency/disaster plan, there was no documentation present indicating communication between the facility and the local disaster management agency. In an interview on 11/4/11 at 9:00 AM, the nurse manager stated contact information for local emergency services was posted by telephones in the dialysis unit. She stated contact had not been made with the local disaster management agency during her tenure as the facility's nurse manager,	V 416	494.60 V416 Nurse Manager or designee will contact Local Disaster Emergency Agency annually to re-establish communication in order to improve patient safety outcomes in the event of a disaster or emergency. See attachment for documentation form. Documentation will be filed in the Emergency Preparedness Binder and retained for one year. Presence of documentation will be verified by annual internal audit by Director of Quality/Education.	Thursday 11-10-2011 Thursday 11-10-2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 416	Continued From page 3 approximately 2 1/2 years. She said she thought the Regional Director was responsible for making the contact. In the same interview on 11/4/11 at 9:00 AM, the Regional Director stated it was each facility's responsibility to make contact with their local disaster management agency. The facility failed to ensure coordination with the local disaster management agency was completed.	V 416		

COPY

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November 22, 2011

Brandy Leaming, Administrator
Liberty Dialysis Hayden
8556 Wayne Drive
Hayden, ID 83835

Provider #132519

Dear Ms. Leaming:

On **November 9, 2011**, a complaint survey was conducted at Liberty Dialysis Hayden. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004916

Allegation #1: Facility patients were hospitalized excessively.

Findings #1: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Seven active and 6 inactive patient records, including hospitalization logs, were reviewed. Facility Quality Assurance data and Dialysis Facility Reports were reviewed.

The facility Quality Assurance and Performance Improvement committee reviewed patient admissions to the hospital on a monthly basis. This included the analysis of frequency of admission, admitting diagnosis, and length of stay for facility patients. Additionally, data from the Dialysis Facility Reports showed the facility had a patient hospitalization rate that was consistent with the hospitalization rate of dialysis patients throughout the country.

For example, one patient record reviewed was that of a 37 year old male who started dialysis at the facility on 4/13/10. His record, as well as his individual hospitalization log, documented he had been hospitalized once during his time as a dialysis patient at the facility. This hospitalization was 4 days in length.

It could not be determined that patients of the facility experienced excessive hospitalizations. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patient complaints were not addressed by the Physician Assistant, resulting in patient hospitalization.

Findings #2: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Staff interviews were conducted, 7 active patient and 6 inactive patient records, and facility policies and procedures were reviewed.

Facility policy stated patients would be assessed by the Physician Assistant at least once a week during dialysis treatments. Additionally, patients would be assessed once a month, during comprehensive dialysis rounds, by the entire IDT including the doctor, social worker, dietician, nurse, and physician assistant.

Review of progress notes documented patients were consistently assessed by the Physician Assistant and the IDT, according to facility policy. For example, progress notes were reviewed for a 37 year old male. These notes documented timely assessments by the Physician Assistant, including assessments on Monday, 8/2/10 and on Tuesday, 8/3/10. On 8/2/10 the patient complained of shortness of breath and nausea. The Physician Assistant noted the patient "appears volume overloaded by exam and remains hypertensive. Fluid challenge, decrease target weight." On 8/3/10 the patient stated he still had some chest pressure but felt slightly better. The Physician Assistant noted the patient "Still appears somewhat volume overloaded. Try decreasing target weight and use critline at next run."

The patient presented to the emergency department of the local hospital on Thursday 8/5/10 and was admitted for treatment of pneumonia.

In an interview on 11/1/11 at 12:00 PM, the Physician Assistant stated she saw patients weekly, during their dialysis treatments. She said she interviewed and examined patients and addressed complaints and problems.

It could not be determined that patient complaints were not addressed by the Physician Assistant. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Information was not provided to other facilities where patients dialyzed while traveling.

Findings #3: An unannounced visit was made to the facility from 10/31/11 -11/4/11. Staff interviews were conducted. Seven active patient records and 6 inactive patient records were reviewed. Facility policy and procedure for dialysis patient travel was reviewed.

Facility policy stated that travel for patients would be arranged and coordinated by a central travel broker at the corporate office.

In an interview on 11/1/11 at 10:00 AM, the facility social worker said she made the initial request to the broker when a patient wanted to travel. The broker then coordinated exchange of information between the sending and receiving facilities.

In the same interview the facility administrative assistant said she was responsible for sending requested information to the receiving facility. She routinely sent a report that included the patient's dialysis prescription and data from several recent dialysis treatments.

Patient record review showed patient travel arrangements were routinely handled according to facility policy. For example, one record reviewed was that of a 37 year old male. Documentation showed he had traveled to other dialysis facilities twice during June 2010 and once during July 2010. One episode of travel took place from 6/15/10 - 6/17/10. The patient was accepted by the receiving facility as confirmed by an e-mail dated 5/25/10. However, when the patient arrived for dialysis, the receiving facility did not have information about his treatment. A subsequent e-mail from the nurse manager of the receiving facility, dated 7/4/11, stated the error was the responsibility of the receiving facility. No concerns were noted for the patient's other two episodes of travel.

It was determined the event did occur and the allegation was substantiated. However, it could not be determined that the the facility's process to provide patient information was not comprehensive. Therefore, no deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients' weight loss is not addressed by the facility.

Findings #4: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Staff interviews were conducted. Seven active patient records and 6 inactive patient records were reviewed.

In an interview on 11/2/11 at 12:00 PM, the facility dietician stated she assessed each patient for weight loss on a monthly basis. Information considered in this assessment included the patient's physical appearance, appetite level, average fluid weight gain between treatments, serum sodium level, and serum Albumin level (a measure of protein in the body). With this information she could determine if the patient was losing body weight or fluid weight. She explained if weight decreased and serum Albumin remained at an acceptable level, the weight loss would usually be attributed to fluid loss. If weight decreased and serum Albumin levels decreased, the weight loss would usually be considered a loss of body weight. She further stated she educated patients on a variety of dietary issues including weight loss. She said the facility had dietary supplements available for purchase by patients to assist with increased protein intake and weight gain if needed. She could also refer a patient for intravenous supplements.

According to GlobalRPh.com, a clinician's reference for blood serum values, normal adult serum Albumin values are 3.2 - 5.0 g/dl. Lower serum Albumin values could be caused by liver disease, kidney disease, or infection. The facility's goal for patient serum Albumin levels was 4 g/dl or greater.

Review of patient assessments for 7 active patients and 6 inactive patients confirmed dietician assessment on a monthly basis, and this information was shared with the Interdisciplinary Team.

For example, one record reviewed was that of a 37 year old male who started dialysis at the facility 4/13/10. His records documented from May 2010 to December 2010 he experienced a 15% weight loss of 37 pounds. However, his record documented appropriate monitoring and interventions as follows:

His weight in May 2010 was 180 pounds and his serum Albumin levels were 4.1 g/dl. A dietician's progress note, dated 8/7/10, documented the patient continued to have a good appetite and improved fluid removal but had experienced an acute illness/infection, had decreasing protein stores, and documented the patient's wife had purchased protein supplements for home use.

His weight was 176 pounds in August 2010 and his serum Albumin levels were 3.5 g/dl.

His weight was 165 pounds in September 2010 and his serum Albumin levels were 3.7 g/dl.

His weight was 163 pounds in October 2010 and his serum Albumin levels were 3.5 g/dl.

His weight was 164 pounds in November 2010 and his serum Albumin levels were 3.6 g/dl. Additionally, Megace (a medication given for its appetite stimulating mechanism) was prescribed in November 2010.

His weights was 153 pounds in December 2010 and his serum Albumin levels were 3.5 g/dl. Additionally, a dietician's progress note dated 12/7/10 documented the patient had scheduled surgical removal of a previously transplanted kidney with anticipated increase in appetite as a result of the surgical intervention.

It could not be determined that the facility failed to address patient weight loss. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients are seen only by a Physician Assistant and visits to the physician's office were denied.

Findings #5: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Staff and patients interview were conducted. Seven active patient records and 6 inactive patient records were reviewed.

In an interview on 11/1/11 at 12:00 PM, the facility Physician Assistant said she routinely assessed patients the first, second and fourth weeks of each month and the Interdisciplinary Team, including the physician, assessed patients the third week of each month. She further stated patients could be seen in the physician's office, which the doctor often suggested for complicated patients.

In an interview on 11/2/11 at 1:00 PM, the facility manager said patients were routinely seen by the Physician Assistant the first, second and fourth weeks of the month on Monday and Tuesday. Patients were seen by the Interdisciplinary Team, including the physician, the third week of the month on Thursday and Friday. She further stated patients could see the physician in his office by calling the office and scheduling an appointment.

Four active patients were interviewed. Three patients said they had access to visits with the physician in his office within 1-2 days after they requested a visit. One patient said he did not know if office visits were available because he had not had a need for this service.

Review of 7 active patient records and 6 inactive patient records showed documentation of physician assessments at the chairside on a monthly basis.

It was determined patients were seen by both the Physician Assistant and the physician and could schedule additional physician's office visits.

It could not be determined that the facility failed to provide visits by the Physician's Assistant to patients. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Patients were permanently removed from the facility treatment schedule when they were away for vacation.

Findings #6: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Staff and patient interviews were conducted. Seven active patient records and 6 inactive patient records were reviewed.

Current patient treatment schedules were reviewed.

In an interview on 11/3/11 at 9:00 AM, the facility nurse manager stated patients' scheduled treatment times were not changed or removed from the schedule when they were temporarily absent from the facility. Patient treatment times were only removed from the schedule if a patient expired or transferred to another facility.

The treatment schedule for treatment days 10/31/11 - 11/4/11 was reviewed. This review showed patients were removed from, and added to, the schedule on a single day basis only.

Three active incenter hemodialysis patients were interviewed. The three patients stated they had not been removed from the treatment schedule when they had been absent from the facility for illness, vacation, or hospitalization.

Review of seven active patient records and 6 inactive records showed no missed or shortened patient treatments due to patients being removed from the treatment schedule. For example, one record reviewed was that of a 37 year old male. The patient was regularly scheduled for the first treatment shift on Tuesday/Thursday/Saturday. He was absent from the facility for vacation on 6/15/10 and 6/17/10. He did not present for his regularly scheduled treatment on 6/19/10, first shift. He presented to the facility in the late afternoon of 6/19/10. Staff offered him his full 4 hour treatment time. The patient refused and signed a refusal form agreeing to a 2 hour treatment.

It could not be determined that the facility permanently remove patients from the treatment schedule during temporary absences. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The facility did not transfer completed patient transplant work up information from one transplant center to another

Findings #7: An unannounced visit was made to the facility from 10/31/11 - 11/4/11. Staff interviews were conducted. Seven active patient records and 6 inactive patient records were reviewed.

In an interview on 11/2/11 at 11:00 AM, the facility social worker stated she was responsible for making the initial patient referral to transplant centers for work up. She further explained that, after the initial referral, the facility did not receive or compile specific information related to the patient's work up. Communication was maintained between the patient and the transplant center. The facility received only copies of communication sent to the patient by the transplant center. No transplant work up information was available to the facility for transfer.

Review of active and inactive patient records showed 3 transplant referrals were made for eligible patients and patient status updates were received from the transplant centers. For example, one record reviewed was that of a 37 year old male who started dialysis at the facility in April, 2010. His record showed he had been referred by the facility to 2 transplant centers in another state, one on 5/14/10, and another on 5/21/10. Five patient status updates were documented in the patient's record from the transplant center of his choice. These updates indicated the patient's transplant work up had not been completed as of 11/19/10.

The facility did not have patient information available to transfer from one transplant center to another. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm