IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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November 21, 2018

Ana Laborde, Administrator
Liberty Dialysis - Nampa
280 West Georgia Avenue
Nampa, ID 83686

RE: Liberty Dialysis - Nampa, Provider #132516

Dear Ms. Laborde:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis - Nampa, which was conducted on November 19, 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 **December 3, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132516	A. BUILDING _____ B. WING _____	11/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS - NAMPA	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 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey at your facility from 11/14/18 - 11/19/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: AVF - Arteriovenous Fistula CVC - Central Venous Catheter DO - Director of Operations ICHD - Incenter Hemodialysis pt - patient PCT - Patient Care Technician QAPI - Quality Assurance Performance Improvement rn - registered nurse tx - treatment	V 000	RECEIVED DEC 03 2018 DIV OF LIC & CERT	
V 628	QAPI-MEASURE/ANALYZE/TRACK QUAL INDICATORS CFR(s): 494.110(a)(2) The dialysis facility must measure, analyze, and track quality indicators or other aspects of performance that the facility adopts or develops that reflect processes of care and facility operations. These performance components must influence or relate to the desired outcomes or be the outcomes themselves. This STANDARD is not met as evidenced by: Based on adverse occurrence reports review, treatment sheet review, and staff interview, it was determined the facility failed to ensure data related to adverse occurrences was accurately	V 628		

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

Joel H. Grooms DIRECTOR 12.3.18

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 628	Continued From page 1 collected. This failure directly impacted 4 of 6 ICHD patients (Patients #1 - #4) whose records were reviewed, and had the potential to impact all patients receiving care at the facility. This failure resulted in the inability by the QAPI committee to identify problem indicators, and the inability to devise an effective action plan to correct the problem indicators. The findings include: A review of facility QAPI meeting minutes from 4/2018 - 8/2018 showed the QAPI committee reviewed facility data, including data related to adverse occurrences, and based process changes and action plans on the data received and reviewed. A policy titled Patient Adverse Event Reporting and Documentation, dated 1/04/12, listed 66 adverse events for which data was to be collected for review by the QAPI committee. These events included infiltration severe enough to interfere with dialysis, blood loss > 100 ml due to clotted dialyzer, and medication errors. In an interview on 11/19/18 at 10:00 A.M., the facility's DO confirmed all staff trained to this policy on an annual basis. Documentation of adverse event reports had not been consistently completed, for review by the QAPI committee, as follows: 1. Patient #1 was a 45 year old female utilizing a new AVF for dialysis. On 11/07/18 her treatment sheet documented a PCT note stating "system clotted pt needs to end tx at regular time." There was no adverse event report documenting this event.	V 628		

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V 628	Continued From page 2 In an interview on 11/19/18 at 9:00 A.M., the charge nurse confirmed Patient #1's treatment had been interrupted due to clotting of the extracorporeal blood circuit. She confirmed an adverse event report had not been completed. 2. Patient #2 was a 46 year old male whose dialysis prescription included 240 minutes of treatment time three times a week. On 10/23/18 his treatment was discontinued after 56 minutes with a nurse's note stating "pt was moving his arm and infiltrated venous needle site...pt advised to use ice on and off over the next 24 hours to help with pain and swelling at the infiltration site." There was no adverse event report documenting this event. In an interview on 11/19/18 at 9:00 A.M., the charge nurse confirmed the infiltration for Patient #2 had interfered with his dialysis treatment and had not been documented as an adverse event. 3. Patient #3 was a 61 year old whose dialysis prescription included 270 minutes of treatment time three times a week. On 11/03/18 his treatment was discontinued 24 minutes early with a nurse's note stating "blood lines clotted tx ended early, will increase heparin dose for next tx." There was no adverse event report documenting this event. In an interview on 11/19/18 at 9:00 A.M., the charge nurse confirmed the infiltration for Patient #3 had interfered with his dialysis treatment and had not been documented as an adverse event. 4. Patient #4 was a 63 year old male who dialyzed using a CVC. His dialysis prescription stated Heparin (an anti coagulant medication)	V 628		

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V 628	Continued From page 3 was to be administered as an 8000 unit bolus dose at the beginning of treatment, and at 1500 units/hour during treatment. Additionally, his CVC was packed with 2100 units, in each of two ports, to prevent clotting between treatments. This CVC packing was to be removed from the CVC prior to treatment. On his 10/17/18 treatment sheet at 5:47 A.M., a PCT note stated "treatment initiated...cound'nt [sic] asparate [sic] venous port rn aware." This resulted in an additional 2100 units of Heparin being administered to Patient #4. Patient #4's bolus and hourly Heparin doses had not been decreased. There was no adverse event report documented for this event. In an interview on 11/19/18 at 9:00 A.M., the charge nurse confirmed the medication error for Patient #4 had not been documented as an adverse event. Accurate adverse event data was not collected and provided to the QAPI committee for review and remedial action.	V 628		

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E 000	Initial Comments No deficiencies were cited during the recertification of your facility, from 11/14/18 - 11/19/18, for Emergency Preparedness. Liberty Dialysis Nampa is in compliance with the requirements of CFR 494.62. The surveyor conducting the survey was: Trish O'Hara RN	E 000	RECEIVED DEC 03 2018 DIV OF LIC & CERT	

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Fresenius Medical Care
Dba Nampa
Plan of Correction for
Medicare ESRD Recertification Survey
Date of Survey: 11/19/2018

V628 QAPI- QAPI- Measure/analyze/track Quality Indicators

The Clinic Manager/designee will educate and elicit input from relevant staff by 12/6/2018 on the expectations and responsibilities to comply with the following policies and procedures:

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

Education emphasis was placed on:

- By 12/31/2018, Learning Modules System: Adverse Event training is completed by all staff, to ensure the knowledge of what is an adverse event.
- Complete documentation is in accordance with Quality Assessment Improvement and Adverse Event Policy.
- Adverse Event is documented in patient health record.
- Enter the Adverse Event Summary for Hemodialysis or Peritoneal Dialysis.
- Notify Clinic Manager of Adverse Event.
- Quality Assessment and Performance Improvement Team monthly, Reviews and evaluates each individual Adverse Event.
- Quality Assessment and Performance Improvement Team trending patient safety, outcome, and ways to prevent said event if applicable.
- If trend is found, Root Cause Analysis is completed, and documented in Quality Assessment Improvement.

Effective 12/3/2018, Clinical Manager or designee will conduct an audit on 1 shift of treatment sheets, 3 times a week, for presence of an adverse event, and if adverse event report was made. Utilizing the Audit Tool for 4 weeks. These audits will be conducted so multiple shifts, and all staff are reviewed. Effective 12/1/2018, Clinical Manager or designee will conduct Bi-weekly preparation for Quality Assessment Improvement using equip Adverse event entry log tool with documentation of checking Adverse Events from Staff. Quality Assessment Improvement minutes to include a greater focus on adverse events and their outcomes for the next 6 Months. Once 90% compliance is sustained, monitoring will be completed per the Quality Assessment and Performance Improvement calendar with oversight from the Governing Body.

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

The Clinical Manager is responsible for reviewing, analyzing, and trending all data and audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement committee monthly.

The Director of Operations is responsible for presenting the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement committee is responsible for providing oversight, review findings, and take actions as appropriate.

The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

Documentation of education, monitoring, Quality Assessment Improvement, and Governing Body is available for review.

The Clinic Manager is responsible for overall compliance.

Completion Date: 12/31/2018