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

March 5, 2015

Tiffany Campbell, Administrator
Nampa Dialysis Center
846 Parkcenter Way
Nampa, ID 83651

RE: Nampa Dialysis Center, Provider #132501

Dear Ms. Campbell:

This is to advise you of the findings of the Medicare survey of Nampa Dialysis Center, which was conducted on February 26, 2015.

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 **March 17, 2015**, 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, option 4.

Sincerely,

Trish O'Hara

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132501	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA DIALYSIS CENTER	916 PARKCENTER WAY NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 2/23/15 - 2/26/15. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: PCT - Patient Care Technician POC - Plan of Care	V 000	V000 On March 12, 2015 the Governing Body (GB) of Nampa Dialysis has reviewed the recertification survey completed February 26, 2015. The GB has developed, approved and respectfully submits the following plan of correction (POC). RECEIVED MAR 17 2015 FACILITY STANDARDS	
V 367	494.60(b)(1) QA AUDITS-REPROCESS PROCED MONTHLY;2X/YR 14.8 Reprocessing: audit monthly; semiannually initially, designated staff members should audit the written procedures for the various steps in this process and verify implementation at least monthly. Subsequently, semiannual audits may be sufficient if there is a documented history of favorable results. Trend analysis should be performed. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to perform dialyzer reprocessing practice audits for 2 of 2 facility reuse technicians whose personnel records were reviewed. This failure created the potential for patient harm due to improper care of reusable dialyzers. Findings include: The Core Survey Personnel File worksheet, completed by the facility, was reviewed and indicated Staff #1 and #2 were PCTs who had been trained to reprocess patients' dialyzers.	V 367	V367 On February 27, 2015, the FA completed a review of Policy & Procedure #06-01-12 Reuse Continuous Improvement Plan including the requirement to complete reprocessing audits of the Reuse program and technician practices monthly, quarterly, semi-annually and annually. In addition, the FA provided an inservice to the reuse technicians on same policy which included an emphasis on the required schedule of reuse practice audits to be completed. A designated trained teammate is now delegated to complete the reuse program audits according to the Conditions for Coverage regulations and policy which includes a monthly, quarterly, semi-annually and annual audit. These audits include visual observation of reuse technician practices and procedures. The FA has delegated and reviewed with the technical supervisor (biomedical technician) to provide the oversight of reuse practice audits. This technician will perform the semi-annual reuse audits and report results to the FA. The FA or designee will review the reuse program audits in the monthly QAPI program with the Medical Director. As according to the Conditions for Coverage regulations under V307, the reuse technicians will complete annual competency and annual recertification of competency for reuse practices. Continued on next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Facility Administrator	3/16/15

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.

PRINTED: 03/04/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132501	A. BUILDING _____ B. WING _____	02/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 367	Continued From page 1 Review of Learning Plan Transcripts for Staff #1 and #2 documented reprocessing competencies had been audited most recently on 4/9/14. In an interview on 2/26/15 at 9:00 a.m., the Facility Administrator stated audits of reprocessing practices were done for facility staff on an annual basis by a corporate educator from another state. The facility failed to perform semi-annual audits of reprocessing procedures and implementation.	V 367	This annual competency documentation will be kept in the teammate's personnel files. Upon review of the QAPI reuse audits and if compliance is not met a root cause analysis will be completed and new plan of correction implemented by the QAPI team. The FA is responsible for this POC.	4/1/15
V 516	494.80(b)(1) PA-FREQUENCY-INITIAL-30 DAYS/13 TX An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 hemodialysis sessions beginning with the first dialysis session. This STANDARD is not met as evidenced by: Based on review of facility policies and medical records and staff interview, it was determined the facility failed to ensure a reassessment was completed for 1 of 1 transfer patients (Patient #1) whose assessment and POC was forwarded to the receiving facility and whose record was reviewed. Failure to complete a reassessment for a transfer patient had the potential to result in unmet needs. Findings include: A policy titled Patient Assessment And Plan Of Care When Utilizing Falcon Dialysis, dated 3/2013, stated a comprehensive reassessment should be initiated 60 days after an experienced patient transferred to the facility. The	V 516	V516 FA or designee held a mandatory in service for all members of Interdisciplinary Team (IDT) and the newly delegated Assessment Manager on March 4, 2015. In service included but was not limited to: Review of Policy & Procedure #1-01-14 Patient Assessment and Plan of Care Utilizing Falcon Dialysis, 1) IDT must ensure that a comprehensive assessment will be conducted on all new patients within 30 calendar days or 13 outpatient dialysis sessions beginning with the first outpatient dialysis treatment, 2) IDT must complete initial plan of care based on the findings from comprehensive assessment on all new patients within 30 calendar days or 13 outpatient dialysis sessions beginning with the first outpatient dialysis treatment. Experienced patients transferring to the center must be reassessed within 60 days and a POC be completed within 15 days of the reassessment. Attendance of in-service is evidenced by teammate signature on in-service form. FA initiated tracking tool for purposes of planning and tracking patient's Interdisciplinary Assessment/Re Assessment and Plan of Care due dates to ensure completion on time. Continued on next page	

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

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132501	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA DIALYSIS CENTER	810 PARKCENTER WAY NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 510	Continued From page 2 reassessment should be completed within 30 days and a POC should be completed within 15 days of the comprehensive reassessment. Patient #1 was a 58 year old male who had been dialyzing at the facility since 5/19/14. Patient #1 was an experienced dialysis patient from another corporate facility. He relocated to the area and therefore required dialysis at a local facility. Patient #1's medical record contained a comprehensive interdisciplinary assessment and POC, from the transferring facility, dated 2/26/14. The Facility Administrator reviewed Patient #1's record on 2/27/15 at 9:00 a.m. She confirmed the date of Patient #1's most recent assessment and POC. She said a reassessment and POC was due on 2/23/15. It had been completed, and was waiting for IDT approval at the 3/2/15 meeting. Several minutes later, the Facility Administrator returned and stated a computer alert system should have made the IDT aware a reassessment and POC was needed for Patient #1 sixty days after his transfer to the facility, but the system had apparently failed to do so. The facility failed to ensure completion of a reassessment and POC for an experienced patient within 90 days of transfer to the facility.	V 510	SW is assigned the managing process, has been provided a review of the online Falcon system responsibilities to update due dates specifically for transfer patients and will review with FA weekly to ensure no patients are missed. The FA or designee will conduct a 100% medical record audit for any missing or past due Assessment and Plan of Care meetings. Assessment and Plan of Care meetings will be scheduled based on audit results. FA or designee will conduct monthly medical record audits for 100% of new admissions to ensure assessment and plan of care documentation is completed according to schedule. This audit will be completed monthly x 4 months, then 10% quarterly thereafter. FA or designee will review results of audits with Medical Director during monthly QAPI with supporting documentation included in the meeting minutes. If compliance is not met a root cause analysis will be completed and new plan of correction implemented by the QAPI team. FA is responsible for this POC.	4/1/15