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 20, 2015

Erich Schwichtenberg, Administrator
Liberty Dialysis - Boise
1109 West Myrtle Street, Suite 120
Boise, ID 83702

RE: Liberty Dialysis - Boise, Provider # Pending

Dear Mr. Schwichtenberg:

This is to advise you of the findings of the Initial Medicare survey of Liberty Dialysis - Boise, which was conducted on March 17, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

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/nw
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132528	A. BUILDING _____ B. WING _____	03/17/2015

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the initial survey of your ESRD facility from 3/9/15 - 3/17/15. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: BP - Blood pressure dl - deciliter EDW - Estimated Dry Weight gm - gram ICHD - Incenter Hemodialysis IV - Intravenous Kg - kilogram (2.2 pounds) MD - Medical Doctor ml - milliliter PCT - Patient Care Technician POC - Plan of Care UF - Ultrafiltration Note: An acceptable Plan of Correction was developed and implemented on site, addressing the deficiencies included in this report.	V 000		
V 463	494.70(a)(12) PR-RECEIVE SERVICES OUTLINED IN POC The patient has the right to- (12) Receive the necessary services outlined in the patient plan of care described in §494.90; This STANDARD is not met as evidenced by: Based on record review and staff interview, it	V 463		

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

Director of Operations 3/20/15

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.

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V 463	Continued From page 1 was determined the facility failed to ensure each patient's right to receive care as outlined in their POCs was upheld for 3 of 3 ICHD patients (Patients #1 - #3) whose records were reviewed. This resulted in patients not receiving medications and not being monitored as ordered by the physician. Findings include: 1. Patient #2 was a 64 year old patient with diagnoses including hypertension and diabetes. Her Hemodialysis Annual Physician Orders for Hemodialysis, dated 1/16/15 and signed by the medical director, stated "MD to be notified of patients with a pre-treatment standing systolic BP of >190 before heparin [sic] or Epogen can be administered, unless otherwise ordered by physician." Twelve treatment records, from 2/9/15 - 3/9/15, were reviewed for Patient #2. On 2/9/15 a treatment record documented Patient #2's pre-treatment standing BP of 217/93. The record also showed 1200 units of Epogen and 2800 units of Heparin were administered to Patient #2 during treatment. There was no documentation the physician had been contacted prior to the medications being administered. On 2/18/15 a treatment record documented Patient #2's pre-treatment standing BP of 228/107. The record also showed 1200 units of Epogen and 2800 units of Heparin were administered to Patient #2 during treatment. There was no documentation the physician had been contacted prior to the medications being administered. On 3/2/15 a treatment record documented Patient	V 463		

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V 463	Continued From page 2 #2's pre-treatment standing BP of 196/97. The record also showed 2800 units of Heparin was administered to Patient #2 during treatment. There was no documentation the physician had been contacted prior to the medications being administered. On 3/4/15 a treatment record documented Patient #2's pre-treatment standing BP of 199/90. The record also showed 1000 units of Epogen and 2800 units of Heparin was administered to Patient #2 during treatment. There was no documentation the physician had been contacted prior to the medications being administered. In an interview on 3/11/15 at 12:30 p.m., the Nurse Manager confirmed the treatment record documentation for Patient #2. He further confirmed the physician had not been notified of Patient #2's BP readings prior to medication administration. In an interview on 3/11/15 at 5:15 p.m., the medical director confirmed he had signed the Hemodialysis Annual Physician Orders for Hemodialysis for Patient #2, and said his expectation was that the order would be followed. 2. Patient #3 was a 56 year old male with diagnoses including anemia. His record documented a physician order for Venofer, 100 mg/treatment for 10 treatments, to begin 2/18/15 and end 3/16/15. Also documented was a physician order for Epogen 3200 units/treatment, to start 2/18/15 with no stop date. Thirteen treatment records, from 2/9/15 - 3/9/15, were reviewed for Patient #3.	V 463		

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V 463	Continued From page 3 On 2/21/15 a treatment record documented Patient #3 did not receive Venofer or Epogen during treatment. In an interview on 3/11/15 at 12:30 p.m., the Nurse Manager confirmed the treatment record documentation for Patient #3. He said Patient #2 had missed his regular treatment on 2/20/15 and made up the missed treatment time on 2/21/15. However, because 2/21/15 was not a regularly scheduled treatment day for Patient #2, his medication orders were not rescheduled to 2/21/15 by the computer, medication labels were not printed, and medication was not given. 3. Patient #1 was a 27 year old female with diagnoses including anemia. Fourteen treatment records, from 2/7/15 - 3/6/15 were reviewed. The records showed Epogen had been put on hold on 2/4/15, and Epogen 1200 units/treatment was restarted on 2/27/15. Laboratory values were reviewed from 12/17/14 - 2/27/15 for Patient #1. A laboratory value for Hemoglobin, dated 2/18/15, was 10.0 gm/dl. According to a Corporate Recommended Anemia Algorithm, dated 10/10/12, Patient #1's Epogen dose was changed to 1200 units 3 times a week. The same algorithm gave a timeline for collecting laboratory specimens and initiating Epogen doses appropriately. According to this timeline, events should have occurred on the following dates: Wednesday, 2/18/15: Facility collects and ships blood samples. Thursday, 2/19/15: Lab receives, processes and	V 463		

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V 463	Continued From page 4 transmits results. Monday, 2/23/1: New Epogen dose entered into electronic system. Wednesday, 2/25/15: Patient receives new dose. However, Patient #1 did not receive the new dose until 2/27/15, missing the prescribed dose on 2/25/15. In an interview on 3/11/15 at 12:30 p.m., the Nurse Manager confirmed the missed Epogen dose for Patient #2. He was unable to determine a cause for the missed dose. The facility failed to ensure Patients #1 - #3 received care as outlined in their POCs. Note: The facility submitted two action plans on 3/13/15 at 9:00 a.m., which outlined corrective actions. The first plan, addressing missed medications, included the following: a. The clinic manager will trend and review all lab results upon receipt and make the appropriate medication adjustments. b. The clinic ward clerk will be educated on how to run medication exception and validation reports on a daily basis and bring any missed medications to the attention of the RN or clinic manager. c. The clinic will be enrolled in the Corporate Anemia automated dosing emails which will generate dosing amounts for each patient.	V 463		

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V 463	Continued From page 5 d. The clinic manager will be enrolled in additional education for the electronic record system. This will include the ordering and rescheduling of patients and patient orders. e. The clinic manager will report monthly updates to QAI committee and this action plan will be reported in the QAI monthly for review. The second plan, addressing the following of MD orders, included the following: a. The clinic manager and staff will be reeducated on company policy and procedure related to patient pre-dialysis assessment. b. The clinic manager will meet with the attending physician to review the annual standing orders and company policy on notifying the physician when a patient is experiencing abnormal blood pressure. c. The clinic manager will monitor 100% of treatment sheets for the next weeks ensuring that all abnormal occurrences or blood pressures have been addressed and communicated to the physicians. This communication is expected to occur prior to dialyzing the patient. d. The clinic manager will work with physician to determine the root cause for increased blood pressure prior to treatment. e. The clinic manager will post standing orders at the RN station for reference and viewing. f. Annual standing orders will be reviewed with RNs at all clinics.	V 463		

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V 463	Continued From page 6 The plans were reviewed and accepted on 3/16/15.	V 463		
V 726	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure medical records clearly portrayed patients' treatment and care for 3 of 3 ICHD patients (Patients #1 - #3) whose medical records were reviewed. This failure created the potential for patients' POCs not being adjusted to meet patients' needs. Findings include: 1. Treatment records documented the fluid removal goal, programmed into the dialysis machine, calculated by subtracting the patient's EDW from his/her pre dialysis weight. The records also documented Actual UF, a value downloaded by the dialysis machine, that showed the amount of fluid actually removed by the machine. In an interview on 3/11/15 at 12:00 p.m., the PCT said a saline amount of 250 ml for initiation of treatment and a saline amount of 250 ml for termination of treatment was added to the patients' fluid removal goals programmed into the	V 726		

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V 726	Continued From page 7	V 726		

dialysis machine. He said these amounts were not routinely recorded on the treatment sheet.

Patient medical records documented the following:

a. Patient #1 was a 27 year old female who had been dialyzing at the facility since 9/8/14. Fourteen treatments, from 2/7/15 - 3/6/15, were reviewed. Inaccuracies in her record pertaining to fluid removal were noted as follows:

On 2/9/15 Patient #1's pre dialysis weight was 70 kg. Actual UF was recorded as 2.7 ml. This would have resulted in an expected post dialysis weight of 67.3 kg. Patient #1's actual post dialysis weight was 67.8 kg, a difference of 500 ml.

On 2/11/15 Patient #1's pre dialysis weight was 71 kg. Actual UF was recorded as 4.3 ml. This would have resulted in an expected post dialysis weight of 66.7 kg. Patient #1's actual post dialysis weight was 67.7 kg, a difference of 1000 ml or 2.2 pounds of fluid.

Additionally, the difference between Patient #1's expected post dialysis weight and actual post dialysis weight was documented as follows:

Date	Expected	Actual	Difference
2/14/15	68 kg	68.8 kg	800 ml
2/16/15	67.6 kg	68.8 kg	1200 ml
2/18/15	66.5 kg	67.0 kg	500 ml
2/20/15	66.7 kg	67.4 kg	700 ml
2/21/15	66.7 kg	67.5 kg	800 ml
2/23/15	66.2 kg	67.4 kg	1200 ml
2/27/15	66.5 kg	67.6 kg	1100 ml
2/28/15	67.0 kg	67.9 kg	900 ml

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V 726	Continued From page 8 3/6/15 68.5 kg 69.4 kg 900 ml There was no documentation on the above noted treatments to indicate why Patient #1 did not attain the expected post dialysis weight, such as additional IV fluid having been given or additional oral fluid having been consumed. This left Patient #1 at risk for complications of fluid overload. b. Patient #2 was a 64 year old female who had been an ICHD patient since 1/16/15. Twelve treatment records, from 2/9/15 - 3/9/15, were reviewed for Patient #2. The difference between Patient #2's expected post dialysis weight and actual post dialysis weight was documented as follows: Date Expected Actual Difference 2/13/15 102 kg 102.8 kg 800 ml 2/16/15 101.4 kg 102.1 kg 700 ml There was no documentation on the above noted treatments to indicate why Patient #2 did not attain the expected post dialysis weight, such as additional IV fluid having been given or additional oral fluid having been consumed. This left Patient #2 at risk for complications of fluid overload. c. Patient #3 was a 56 year old male who had been dialyzing at the facility since 11/3/14. Thirteen treatment records, from 2/9/15 - 3/9/15, were reviewed for Patient #3. The difference between Patient #3's expected post dialysis weight and actual post dialysis weight was documented as follows: Date Expected Actual Difference 2/16/15 80.9 kg 79.9 kg -1000 ml	V 726		

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V 726	Continued From page 9 There was no documentation on the above treatment to indicate why Patient #3's post dialysis weight was significantly less than expected. This left Patient #3 at risk for complications of dehydration. In an interview on 3/11/15 at 12:30 p.m., the Clinical Coordinator confirmed the discrepancies in treatment records for Patient #1 - #3. The facility failed to accurately and completely document dialysis treatments for Patient #1 - #3. Note: The facility submitted a plan of correction on 3/16/15 at 3:00 p.m., addressing weight discrepancies as follows: a. Patients will be monitored by two staff members when weighing in and out for each treatment to ensure proper weight reporting. b. All fluids brought into dialysis for consumption will be documented. c. Prime and rinseback amounts will be documented on treatment sheets to ensure correct reporting. d. Treatment sheets will be checked for accuracy and data entry errors daily. e. The facility scale will be professionally inspected and serviced, if needed. The plan was reviewed and accepted on 3/16/15.	V 726		