COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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October 11, 2012

Ms. Terry Whybark, Administrator
Palouse Dialysis Center
723 South Main Street
Moscow, ID 83843

RE: Palouse Dialysis Center, Provider #132520

Dear Ms. Whybark:

This is to advise you of the findings of the Medicare survey of Palouse Dialysis Center, which was conducted on October 5, 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.

After you have completed your Plan of Correction, return the original to this office by **October 24, 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

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132520	A. BUILDING ______ B. WING ______	10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOUSE DIALYSIS CENTER	723 SOUTH MAIN STREET MOSCOW, ID 83843

(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 The following deficiencies were cited during the recertification survey of your ESRD facility. The surveyor conducting the survey was: Trish O'Hara, R.N.	V 000	See Attached Plan of Correction	
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure supplies were dedicated for use on a single patient. This failure directly impacted 3 of 3 patients (Patients #4, #10, and #12) observed, and had the potential to impact all patients dialyzing at the facility using an extremity access. Findings include: During an observation on 10/3/12 from 10:00 AM - 11:15 AM, precut strips of tape were noted to be stuck to the tabletop at the supply station. Two	V 116	RECEIVED OCT 25 2012 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Area mgr (X6) DATE: 10-25-2012

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.

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

PRINTED: 10/10/2012
FORM APPROVED
OMB NO. 0938-0391

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V 116	Continued From page 1 patient care technicians were observed accessing these strips of tape, taking them to several patient care stations (Patients #4, #10, and #12), and using them to secure vascular access needles for patients having dialysis initiated on the second shift of the treatment day. In an interview on 10/3/12 at 11:30 AM, a patient care technician stated one of her duties, during morning preparations for patient treatments, was to tear strips of tape for all patient treatments to be done that day. She said the strips remained on the tabletop at the supply station and were used throughout the day to secure patients' access needles. In an interview on 10/4/12 at 1:30 PM, the facility Nurse Manager confirmed that taking tape strips from a communal source to individual patient care stations was an infection control issue that created the potential for cross contamination. The facility failed to ensure supplies that could not be disinfected were dedicated to a single patient.	V 116	See POC Attached	
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	V 416		

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V 416	Continued From page 2 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, due to 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 10/2/12 at 3:00PM, the nurse manager stated she had made one telephone contact with the local disaster management agency but did not document the date or content of the conversation. She said she was unsure what resources the agency might have available to the facility in case of a local disaster. The facility failed to ensure coordination with the local disaster management agency was completed.	V 416	See POC Attached	
V 727	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts.	V 727		

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V 727	Continued From page 3 (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to keep patient records secure at all times, impacting 18 of 18 patients (Patients #1 - #18) who received services at the facility. This failure allowed the potential for the acquisition of confidential patient information by unauthorized persons. Findings include: An unattended reception area was present between the facility lobby and the treatment area. Unsecured, open glass sliding windows separated the lobby and the reception area. An unsecured door from the lobby provided access to the reception and treatment areas. Eighteen clinical records, for in center hemodialysis and home dialysis patients (Patients #1 - #18), were stored in unsecured cupboards within the reception area. Patient information to be filed was kept on a desktop in the reception area. From 10/2/12 - 10/4/12 the reception desk was used as a work area by the surveyor who observed patients, family members, delivery persons, and the general public accessing the lobby as well as the unsecured door to the reception and treatment areas. In an interview on 10/4/12 at 2:00 PM, the facility	V 727	See POC Attached	

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V 727	Continued From page 4 administrator confirmed confidential patient information was unsecured and accessible to unauthorized persons. Medical records were not kept in a secured, inaccessible area.	V 727	See POC Attached	

Fresenius Medical Care

Palouse Dialysis Center
Plan of Correction
Dates of Survey: October 2nd thru 5th, 2012

Exit interview was conducted on October 5th, 2012. In attendance, in person and/or telephonically were; Medical Director, Area Manager, Clinic Manager, Bio-Medical Representative, Regional Vice President, Regional Quality Manager and Regional Educational Director.

On October 5th, 2012, in response to the deficiencies cited in the exit interview, the Area Manager met with Clinic Manager to discuss deficiencies cited under V116, V416 and V727. The following outlines what has been, or will be, put in place to correct deficiencies.

1. **Standard level citation under V116: 494.30(a)(1)(i) Infection Control: Items taken into dialysis station should either be disposed of, dedicated for use only on a single patient or cleaned or disinfected before being taken to a common clean area.**

   - The cited deficiency has or will be corrected by the following:
     a) On October 8th, 2012, all patient care staff was educated on the process to prepare and/or manage tape dedicated to a single patient.
     b) By October 26th, 2012, all patient care staff will participate in Infection Control; education and training conducted by the Area Manager and Clinic Manager to emphasize patient tape management and review Fresenius Medical Care Policy & Procedure **{FMS-CS-IC-II-155-110A}**[1] Cleaning and Disinfecting.
     c) Clinic Manager to monitor staff performance and address further issues through any or all of the following: Education, Counseling and/or corrective action.
     d) Monitoring for continued compliance will be conducted through:
        1) Utilizing the Quality Assessment and Improvement Infection Control audit tool; daily times two weeks, weekly times one month, biweekly times one month and monthly time three months by Clinic Manager or designee beginning October 29th, 2012, with the expected to be at 100% compliance.
        2) Clinic Manager is responsible to review, analyze and trend the infection control audit results and present to Area Manager and Medical Director during monthly QAI meetings, beginning November, 2012 and continue until compliance is established.

[1] See FMS Policy attached

Fresenius Medical Care

Palouse Dialysis Center
Plan of Correction Continued

2. **Standard level citation under V416: 494.60(d)(4)(iii) PE-Contact Local EOC Annually.**

- The cited deficiency has or will be corrected by the following:
  a) On October 22nd, 2012, the Clinic Manager reviewed the following:
    1) FMS Annual Facility Local Disaster Management Agency Contact Information Policy Plan **{FMS-CS-IC-I-101-055A}**
    2) FMS Annual Facility Local Disaster Agency Contact Information Plan Procedure **{FMS-CS-IC-I-101-055C}**
    3) Annual Notification Requirement-Local Emergency Operations Center **{FMS-CS-IC-I-101-055D1}**
    4) Local Emergency Operations-Annual Contact Confirmation Form **{FMS-CS-IC-I-101-055D2}**[2]
  b) Continued correction and/or compliance will be conducted through the following:
    1) By or before October 29th, 2012, a letter will be sent to the local disaster planning agency (Latah County) to ensure that the agency is aware of the dialysis facility's needs in the event of an emergency.
    2) It is expected that on or before November 9th, 2012, an acknowledgement of letter will be received from the local disaster planning agency (Latah County)
    3) Monitoring for continued compliance will be performed by utilizing the QAI Local Disaster Management Agency Communication, at a minimum of yearly, by the Area Manager or designee

[2] See Local Disaster information attached

Fresenius Medical Care

Palouse Dialysis Center
Plan of Correction Continued

3. **Standard level citation under V727: 494.17(a) MR-Protect Pt Records FM Loss/Confidential.**

- The cited deficiency has or will be corrected by the following:
    a. On October 8th, 2012, key entry locks were installed on medical record cabinets to protect patient personal information
    b. Beginning October 8th, 2012, it will be the Clinic Manager or designee responsibility to assure all patient personal information is secure from unintentional viewing by unauthorized person or persons during the clinics hours of operation
    c. Beginning October 8th, 2012 it will be the Clinic Manager or designee responsibility to secure medical records, or any documentation containing patient personal information, within the lockable medical record cabinets to protect patient personal information from intentional or unintentional viewing by unauthorized person or persons during hours of non-operation
    d. By October 26th, 2012, all staff will participate in Medical Record education and training conducted by the Area Manager and Clinic Manager with the emphasis on safeguarding patient personal information
    e. By October 26th, 2012 all staff will review policy; Medical Record Guideline Policy **{FMS-CS-IC-II-150-037A}**[3]

Submitted

Clinton T. Fairless
Fresenius Medical Care
Idaho Area Manager
208-762-4411 (office)
208-659-7740 (cell)

10/24/2012
Date

[3] See Medical Record Policy Attached