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

CERTIFIED MAIL: 7007 3020 0001 4038 9840

June 19, 2014

Maria Gumucio-Powell, Administrator
Liberty Dialysis Meridian
3525 E Louise Dr, Suite 100
Meridian, ID 83642

RE: Liberty Dialysis Meridian, Provider #132512

Dear Ms. Gumucio-Powell:

Based on the survey completed at Liberty Dialysis Meridian, on June 10, 2014, by our staff, we have determined Liberty Dialysis Meridian is out of compliance with the Medicare ESRD Condition for Coverage of **CFC- Patient Plan Care (42 CFR 494.90)**. To participate as a provider of services in the Medicare Program, an ESRD must meet all of the Conditions for Coverage established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Liberty Dialysis Meridian, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition for Coverage referenced above by subinitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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 each form.

Such corrections must be achieved and compliance verified by this office, before July 25, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than July 17, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **July 1, 2014**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me 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/pmt
Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

LIBERTY DIALYSIS
PATIENT FOCUSED • PHYSICIAN DRIVEN

3525 E. Louise Dr., Ste. 100
Meridian, ID 83646

Tel 208.846.9815
Fax 208.884.2032

July 1st, 2014

Trish O'Hara, Health Facility Surveyor
Idaho Department of Health & Welfare
3232 Elder Street
Boise, ID 83720-0009

Re: Liberty Dialysis-Meridian, CMS #132512

Dear Ms. O'Hara:

This letter is in response to the Idaho Department of Public Health letter to facility management dated June 19, 2014, regarding the Recertification survey dated June 10, 2014. It is to provide credible allegation that the deficiencies cited as a result of the survey have been or will be corrected by July 17th, 2014, as requested in the letter accompanying the statement of deficiencies and that the facility will be in full compliance by that date.

The Governing Body of Liberty Dialysis-Meridian and Fresenius Medical Care-North America take seriously their responsibility to ensure that the Meridian Dialysis facility demonstrates responsibility for providing optimal and safe care. Therefore effective immediately the following actions have occurred.

- The Governing Body completed a review on June 27th, 2014, of the requirements as noted within the Comprehensive Intradisciplinary Assessment and Plan of Care Policy with the direction to provide an inservice to all members of the IDT as to the requirements to document – emphasizing that all staff members must complete their respective sections of the CIA / POC fully.
- An inservice and reeducation was presented on June 12th, 2014, to all IDT members. A sign-in sheet is available at the facility for review.

The Governing Body is responsible for the oversight and compliance with the above policy.

- The Clinical Manager is analyzing and trending all completed CIA/ POCs and is presenting the data monthly to the QAPI Committee for oversight and review.

- Minutes of the Governing Body and QAPI meetings provide evidence of these actions, the Governing Body's direction and monitoring of facility Compliance with the facility's plan of correction. These are available for review in the facility.

I believe that, as a result of the changes made through the Governing Body actions, the implementation of the above described corrective actions, processes and monitoring systems, as

LIBERTY DIALYSIS
PATIENT FOCUSED • PHYSICIAN DRIVEN

3525 E. Louise Dr., Ste. 100
Meridian, ID 83646

Tel 208.846.9815
Fax 208.884.2032

well as the company's local, regional and corporate support for facility operations; the Meridian Dialysis facility is operating in compliance with the Plan of Correction for the Idaho Department of Health's.

If you have questions, I can be reached at 21-277-3507 or angie.schroeder@fmc-na.com . I look forward to your response regarding the above stated requests and thank you for your consideration.

Sincerely,

Angie Schroeder
Director of Operations, Central CO/SW Idaho Area
Liberty Dialysis-Meridian
Fresenius Medical Care North America

Cc:
Luca Chiastra, Regional Vice President – Rocky Mountain Region
Tracy Flitcraft, Regional Quality Manager (RQM) – Rocky Mountain Region
Traci Simpson, Field Vice President Quality – FMCNA Great Plains Group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 6/02/14 - 6/10/14. The surveyors conducting the survey were: Trish O'Hara, RN, Team Lead Don Sylvester, RN Acronyms used in this report include: AMA - Against Medical Advice BFR - Blood Flow Rate CM - Clinic Manager CVC - Central Venous Catheter DFR - Dialysate Flow Rate EDW - Estimated Dry Weight ESA - Erythropoetin Stimulating Agent Ferritin - measure of stored iron FMS - Fresenius Medical Services Hgb - Hemoglobin (oxygen carrying red blood cell) ICHD - In Center Hemodialysis IDT - Interdisciplinary Team kg - kilogram = 2.2 pounds MAT - Measures Assessment Tool NR - Non Reuse PCT - Patient Care Technician PD - Peritoneal Dialysis POC - Plan of Care PT - Physical Therapy RN - Registered Nurse Tsat - measure of iron circulating in the blood	V 000		
V 101	494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS The facility and its staff must operate and furnish	V 101		

RECEIVED
JUL - 1 2014
FACILITY STANDARDS

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

[signature] Director of Operations 7/1/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 101	Continued From page 1 services in compliance with applicable Federal, State, and local laws and regulations pertaining to licensure and any other relevant health and safety requirements. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure patient assessments were completed in accordance with State Rule for 14 of 14 patients (Patients #11 - #24) whose care was observed. This placed all patients dialyzing at the facility at risk of an untreated unstable condition. Findings include: 1. The Rules of the Idaho Board of Nursing, IDAPA 23.01.01.490.06.a, state " Unlicensed assistive personnel may not be delegated procedures involving acts that require nursing assessment or diagnosis..." Additionally, a facility policy titled "Patient Evaluation Post Dialysis Treatment," dated 7/4/12, stated "FMS patient care staff will complete an evaluation post dialysis treatment on every patient." A facility procedure titled "Patient Evaluation Post Dialysis Treatment," dated 7/4/12 stated "Patient assessment is a nursing responsibility and cannot be delegated to unlicensed patient care staff." In an interview on 6/10/14 at 11:00 A.M. the Clinic Manager said all her nurses did pre and post dialysis assessments. She said the post assessment included the patient's mode of discharge, orientation, and any physical or mental change from the pre-dialysis assessment.	V 101	**V 101: 494.20 COMPLIANCE WITH FED/STATE/LOCAL LAWS** The Clinical Manager organized a mandatory staff training for all direct patient care staff to review the following policies and procedures: FMS-CS-IC-I-110-132A Patient Evaluation Post Dialysis Treatment Policy FMS-CS-IC-I-110-132C Patient Evaluation Post Dialysis Treatment Procedure FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy Rules of the Idaho Board of Nursing IDAPA 23.01.01.490.06 Prohibitions & Limitations All staff will complete training on 6/30/14 and 7/1/14. An attendance form for acknowledgement of the training will be signed by each staff member and available in the facility for review. Additionally, beginning 7/2/14 audits utilizing the Post Assessment audit tool will be conducted randomly twice a week on 25% of the patients for 4 weeks to monitor the effect of staff education and	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 101	Continued From page 2 However, during observations in the dialysis treatment area on 6/2/14 from 9:15 - 11:15 A.M., fourteen ICHD patients (Patients #11 - #24) were observed to complete their dialysis treatments and leave the facility while under the care and direction of PCTs. None of the fourteen patients had contact with, or examination by the RN. In an interview on 6/3/14 at 10:30 A.M., a PCT stated the RN signed a chairside computer screen at the end of each patient treatment. This screen contained data collected by the PCT at the end of the patient's treatment. She stated she would call the nurse to examine the patient "if I think something is not right." In an interview on 6/3/14 at 10:35 A.M., the RN said she would look at patients as they left the treatment floor to make sure their mode of discharge (meaning ambulatory, wheelchair, etc.) was the same as it was when they entered the floor prior to treatment. She said she did not do a hands on assessment of patients at the end of their treatments. The facility failed to ensure post dialysis assessments were completed by the RN.	V 101	staff compliance. Audit results will be shared with the staff to review progress and address root causes of any observed non-compliance. Noncompliance will be addressed by the Clinical Manager including re-education and corrective action as appropriate. Documentation will be available in the facility for review. Audit results will be presented to the QAI team beginning at the July meeting scheduled for 7/27/2014. Based on the audit results, the QAI team will make a determination as to the frequency of the audits moving forward. Once the QAI team has seen demonstrated improvement, the audit frequency may be decreased. The Clinical Manager is responsible to review, analyze, and trend the results of all audits and present to the QAI committee for review and oversight.	
V 112	494.30(a) IC-CDC MMWR 2001 The facility must demonstrate that it follows standard infection control precautions by implementing- (1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality	V 112	The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 112	Continued From page 3 Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html. The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure standard infection control precautions were implemented for 1 of 4 patients (Patient #11) whose dialysis was observed to be initiated using an upper extremity vascular access. This failure resulted in the potential for transmission of infection through cross contamination. Findings include: 1. During an observation on 6/2/14 at approximately 10:45 A.M., a PCT was observed at station #2 preparing Patient #11's left upper	V 112	**V 112: 494.30(a) IC-CDC MMWR 2001** The Clinical Manager organized a mandatory staff training for all direct patient care staff to review the following procedure: FMC-CS-IC-I-115-005CI Administration of Intradermal Lidocaine Procedure All staff completed training on 6/12/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review. Additionally, beginning 6/30/14 audits utilizing the Medication Preparation and Administration Audit tool will be randomly conducted twice a week for 4 weeks to monitor the effect of staff re-education and staff compliance. Audit results will be shared with the staff to review progress and address root causes of any observed non-compliance. Noncompliance will be addressed by the Clinical Manager including re-education and corrective action as appropriate. Documentation will be available in the facility for review.	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 112	Continued From page 4 extremity access for cannulation prior to dialysis. Two unmarked syringes, containing a clear liquid, were present on the chairside table. The PCT subcutaneously (under the skin) injected the clear liquid into 2 separate areas of Patient #11's dialysis access. The site was not cleaned with an antiseptic prior to the injections. The PCT then proceeded to cannulate Patient #11's access with dialysis needles. During the observation, the PCT was interviewed. When asked, the PCT, stated the syringes were filled with Lidocaine (a local anesthetic). A facility policy titled "Administration of Intradermal Lidocaine," dated 7/4/12, stated "Select needle sites. Perform skin disinfection." The policy included directions for disinfecting the skin surface with 70% isopropyl alcohol, Povidone Iodine pad, or 2% Chlorhexidine and 70% alcohol. The Clinic Manager was interviewed on 6/10/14 at 9:15 A.M. She confirmed the PCT should have cleaned the sites with an antiseptic before breaking the skin barrier. The facility failed to ensure medications were administered in a safe manner, necessary to minimize the transmission of infectious agents.	V 112	Audit results will be presented to the QAI team beginning at the July meeting scheduled for 7/27/14. Based on the audit results, the QAI team will make a determination as to the frequency of the audits moving forward. Once the QAI team has seen demonstrated improvement, the audit frequency may be decreased. The Clinical Manager is responsible to review analyze and trend the results of all audits and present to the QAI committee for review and oversight. The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment	V 401	**V 401: 494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT** The Clinical Manager organized a mandatory staff training on for all direct	6/23/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 401	Continued From page 5 environment. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a safe environment for patients, staff, and visitors. This failure allowed the potential for severe injury, from compromised oxygen cylinders, to all persons in the facility. Findings include: 1. A facility tour was conducted on 6/2/14 at 9:15 A.M. Three oxygen cylinders were observed to be free standing in the storage room, not secured in a rack or to the wall. The tanks were sealed, indicating they were full. The American National Standards Institute Safety and Health fact Sheet #30, March 2005, addressed compressed gas cylinders stating "Cylinders, with their high internal pressure, are very hazardous when exposed to damage from falling over or tipping...Such damage can cause the cylinder to rupture and explode sending sharp metal pieces, like shrapnel, blasting through the area." The safety instructions stated "Store cylinders upright and secure them with a chain, strap, or cable to a stationary building support or to a proper cylinder cart to prevent them from tipping or falling." In an interview on 6/10/14 beginning at 9:45 A.M., the Clinic Manager confirmed all oxygen tanks needed to be secured in some fashion to prevent tipping and rupture. The facility failed to ensure a safe environment for patients and staff by securing oxygen cylinders.	V 401	patient care staff to review the following procedure: HSEAES&RM-EHS-11-1910 Compressed Gas Storage & Handling Program All staff completed training on 6/12/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review. On 6/10/14, a secure rack for the oxygen tanks was ordered by the bio-med personnel. The rack was received on 6/19/14 and was immediately put in use. Additionally, on 6/23/14 a visual audit was conducted by the bio-med personnel to ensure all oxygen tanks were secured. The audit result showed that all oxygen tanks were secured. Going forward, the bio-med personnel will conduct a monthly physical plant audit to ensure all oxygen tanks are secure. The bio-med personnel will report the finding to the QAI Committee monthly beginning July 27, 2014 to ensure on-going compliance. The QAI Committee is responsible to review/analyze all data including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 463	Continued From page 6	V 463		
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 was determined the facility failed to ensure patients' rights to receive care as outlined in their POC was upheld for 2 of 4 ICHD patients (Patients #2 and #4) whose treatment records were reviewed. This resulted in patients not dialyzing for their prescribed length of time and being left at risk for complications of inadequate dialysis. Findings include: 1. The facility used an AMA form to document shortened treatments. Data from the forms was included in QAPI tracking reports for lost treatment time and patient care conferences for updating POCs. The form was signed by the patient indicating replacement time had been offered and declined. a. Patient #4 was a 71 year old female ICHD patient. Her dialysis prescription included a treatment time of 3.5 hours, three times a week. Twelve treatments were reviewed for Patient #4 from 5/6/14 - 5/31/14. Twelve of twelve treatments were shortened as follows: Date Actual time Time lost 5/6/14 1:59 91 minutes 5/8/14 2:05 85 minutes	V 463	monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained. **V 463: 494.70 (a)(12) PR-RECEIVE SERVICES OUTLINED IN POC** The Clinical Manager organized a mandatory staff training on for all direct patient care, MSW and RD staff to review the following policy: FMS-CS-IC-I-110-144A Early Termination or Arriving Late for Treatment Policy All staff completed training on 6/30/14 and 7/1/14. An attendance form for acknowledgement of the training will be signed by each staff member and available in the facility for review. Beginning 6/30/14, the CM will complete weekly treatment sheet documentation audits to ensure that AMA forms are being signed for each shortened treatment. These audits will be completed weekly for 4 weeks. The results of the audits will be reported to	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 463	Continued From page 7	V 463	the Governing Body weekly starting July 3, 2014.	

5/10/14	2:05	85 minutes
5/13/14	2:01	89 minutes
5/15/14	1:36	114 minutes
5/17/14	2:00	90 minutes
5/20/14	1:59	91 minutes
5/22/14	1:55	95 minutes
5/24/14	2:01	89 minutes
5/27/14	2:03	87 minutes
5/29/14	1:50	100 minutes
5/31/14	2:01	99 minutes

Total dialysis time lost by Patient #4 during May, 2014 was 18.5 hours. AMA forms were signed by the patient on 5/10, 5/15, 5/24, and 5/27/14. These AMA forms documented 6.25 hours of lost treatment time. Eight shortened treatments, representing 12.25 hours of lost treatment time, were not documented for Patient #4.

b. Patient #2 was a 27 year old female ICHD patient. Her dialysis prescription included a treatment time of 4 hours three times a week and 2 hours once a week. Thirteen treatments were reviewed for Patient #2 from 5/3/14 - 6/3/14. Five of thirteen treatments were shortened as follows:

Date	Actual time	Time lost
5/8/14	3:05	55 minutes
5/13/14	1:04	176 minutes
5/27/14	2:47	73 minutes
5/29/14	3:21	39 minutes
6/2/14	1:58	2 minutes

Total dialysis time lost by Patient #2 during May, 2014 was 5 hours 45 minutes.

There were no AMA forms documenting Patient #2 had lost dialysis time or had been offered additional treatments to replace the lost time.

The Clinical Manager is responsible to review, analyze, and trend the results of all audits and present to the QAI committee for review and oversight.

The QAI Committee is responsible to review/analyze all data including monitoring results for prescribed versus actual treatment time, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.

V 540: 494.90 CFC-PATIENT PLAN OF CARE

7/17/14

The Governing Body acknowledges its responsibility to ensure that Liberty Dialysis-Meridian has implemented a "Comprehensive Interdisciplinary Assessment and Plan of Care" process as defined in #FMS-CS-IC-I-110-125A " to ensure that every patient has a timely, complete and current Comprehensive Assessment and Plan of Care completed by all members of the IDT which is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 463	Continued From page 8 In an interview on 6/10/14 at 11:00 A.M. the Clinic Manager confirmed the undocumented lost time for Patients #2 and #4. She said the AMA form was the only data collection that reflected lost time in QAPI and Care Planning and an AMA form should be signed by patients for all shortened treatments. The facility failed to ensure ICHD patients received their prescribed treatments.	V 463	available within their medical record and meets all criteria. The Governing Body, on 6/27/2014 reviewed the SOD and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The following action steps were implemented.	
V 540	494.90 CFC-PATIENT PLAN OF CARE This CONDITION is not met as evidenced by: Based on clinical record review and staff interviews, it was determined the facility failed to develop comprehensive patient POCs for 3 of 10 patients (Patient #2, #4, and #10) whose records were reviewed. This failure resulted in the risk of inadequate care being provided to patients. 1. Refer to V463 as it relates to the facility's failure to ensure patients received dialysis treatment as prescribed. 2. Refer to V541 as it relates to the facility's failure to ensure patient POCs were comprehensive. 3. Refer to V543 as it relates to the facility's failure to ensure patients' volume status was managed. 4. Refer to V557 as it relates to the facility's failure to ensure initial patient POCs were completed in a timely manner.	V 540	The Governing Body will meet weekly to monitor the progress of the Plan of Correction until the Condition level deficiencies are lifted, then monthly for an additional three months to ensure that the corrective actions have resulted in resolution of the cited issues. Once this is determined, the Governing Body will return to quarterly or as needed meetings. Effective immediately: • The Clinical Manager (CM) will analyze and trend all data and monitoring/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	494.90 POC-GOALS=COMMUNITY-BASED STANDARDS The interdisciplinary team as defined at §494.80 must develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient's needs, as identified by the comprehensive assessment and changes in the patient's condition, and must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards. This STANDARD is not met as evidenced by: Based on staff interview and medical record review, it was determined the facility failed to ensure staff developed comprehensive POCs with outcome goals and projected timeframes for reaching the goals, for 3 of 10 patients (#2, #4 and #10) whose records were reviewed. This resulted in a lack of information being available to facility staff regarding patient interventions. The findings include: 1. Patient #4 was a 71 year old female ICHD patient. Her dialysis prescription included dialysis time of 3.5 hours three times a week. She had been hospitalized for treatment of sacral and right buttock pressure ulcers and was discharged from the hospital on 4/25/14 with a negative pressure wound vac system in place. Discharge instructions for wound care stated Patient #4 should be repositioned every 2 hours, using a turn and position system, and she should	V 541	• A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda. • The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues • The Director of Operations (DO) will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. • Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committee's ongoing monitoring of facility activities. These are available for review at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3526 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 10 wear Prevalon boots to prevent pressure ulcers on her heels. She was to follow up with her wound care doctor for continued care. A POC for Patient #4 was dated 5/22/14. Skin care was addressed under the Patient Education for Diabetics section. The expected outcome was stated as "BG (blood glucose) WNL (within normal limits), no foot/mouth/skin sores, takes diabetic meds as prescribed." There was no individualized plan developed that included Patient #4's skin care orders from her hospital discharge or updated information on changes to wound care procedures from the wound care doctor. There was no estimated timetable when the goals were expected to be attained or the plan was expected to be revisited and adjusted. Further, three additional areas of the POC did not include an estimated timetable when goals would be met or the plan would be revisited for adjustment as follows: a. Dialysis prescription - Patient #4's POC showed a current adequacy value of Kt/V = 0.87. The goal was to attain an adequacy value of Kt/V >1.2. The expected outcome stated "Pt. to follow recommended treatment prescription." There was no estimated timetable stating when the goal would be reached or when the plan would be revisited and adjusted. b. Blood Pressure and Fluid Management - The goal for this section was "Achieves BP control." Patient #4's expected outcome stated "pt. to complete full treatments." There was no	V 541	• The responses provided for V Tag's: V463, V541, V543, V557, describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance. **V 541: 494.90 POC-GOALS=COMMUNITY-BASED STANDARDS** The Clinical Manager organized a mandatory staff training for all Registered Nurses, MSW, and Registered Dietitian staff to review the following policy: FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy All staff completed training on 6/12/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review. On 6/15/14, an audit was performed by the CM and RNs on the patients' Plan of Care. On 6/16/14, the CM and Director of	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 11 estimated timetable stated when the goal would be reached or when the plan would be revisited and adjusted. c. Anemia Management - Patient #4's POC showed a Hgb value of 9.2, with a goal of 10-11. A Tsat value of 24 was documented, with a goal of 30-50. The expected outcome stated "pt. to have Hgb, Tsat + ferritin within acceptable range." There was no estimated timetable stating when the outcome would be reached or when the plan would be revisited and adjusted. Additionally, the plan to achieve the specified anemia goal was to "continue to monitor Hgb,ferritin & tsat," and "Review patient education about anemia/iron." "Change ESA dose" was an option for achieving the anemia goal, but it was not included in Patient #4's POC. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager confirmed the POC for Patient #4 was not adequately developed. The facility failed to ensure Patient #4's POC comprehensively addressed her skin issues, included adequate interventions for anemia management, and addressed plan adjustments by the IDT to achieve goals set. 2. Patient #10 was a 65 year old male PD patient. He experienced an infection and loss of his PD catheter on 3/12/14. He received hemodialysis from 3/13/14 - 4/29/14. He returned to the PD program on 4/30/14. Patient #10's initial PD POC, signed by the IDT and the patient's wife on 5/15/14, was reviewed with the following results:	V 541	Operations reviewed the results of the audit. The non-compliant POCs will be completed by the Interdisciplinary Team as required by Policy FMS-CS-IC-I-110-125A, which includes adequate interventions for anemia management, addressed plan adjustments by the IDT to achieve goals set, dialysis access, adequacy, fluid management, rehabilitation status, education needs, and transplant status, by July 17, 2014. Going forward, the CM will ensure that all POCs are completed accurately and entirely by reviewing each POC prior to the care conference meeting date on a monthly basis. The Clinical Manager is responsible to review, analyze, and trend the results of all audits and present to the QAI committee for review and oversight. The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 12 a. Dialysis Access - This section of the POC was blank. No information was given indicating what access type was being used for dialysis or how Patient #10 would be educated to care for it. There was no goal, no plan and no expected outcome or estimated timetable. b. Anemia Management - This section of the POC was blank. No information was given indicating Patient #10's anemia status. There was no goal, no plan, and no expected outcome or estimated timetable. c. Rehabilitation Status - The section titled "Issues identified in comprehensive assessment related to rehabilitation status" stated "refer to PT to increase strength and improve balance." Under expected outcome, Patient #10 was marked "at goal" indicating Patient #10's goal was to be weak and unbalanced. d. Patient Education - This section of the POC was blank. No information was given to indicate Patient #10 was to receive education in any area including the prevention of infection. Under Diabetes Education, boxes were checked for self management of diet, exercise, footchecks, blood glucose monitoring and diabetes meds, indicating additional education was needed based on the comprehensive assessment. However, no goal or plan for achieving goals was included. Under expected outcome and estimated timetable the word "Goal" was written. e. Transplantation - This section indicated Patient #10 was not on a transplant list with the reason listed as "medically unstable." Under the expected outcome section Patient #10 was noted	V 541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 13 to be "at goal" indicating his goal was to be medically unstable and not be listed for transplant. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager confirmed the POC for Patient #10 was not adequately developed. The facility failed to ensure Patient #10's POC comprehensively addressed his dialysis access, anemia status, rehabilitation status, education needs, or transplant status. 3. Patient #2 was a 27 year old female ICHD patient. Patient #2's annual POC, dated 3/18/14, was reviewed with the following results: a. Dialysis Prescription - This section indicated Patient #2's adequacy status was "unknown." No goal was identified, no plan to achieve a goal was created, and there was no expected outcome or estimated timetable for achievement of goal. b. Blood Pressure & Fluid Management - A current EDW was identified as 55 kg. Patient #2's goal was to "achieve EDW." The plan to attain goal was stated as "Assess fluid gains and discuss with patient" and "Provide education..." No expected outcome was determined and no estimated timetable indicated when the goal would be achieved or when the plan would be adjusted by the IDT. Additionally, the facility's hospitalization log indicated Patient #2 was hospitalized for fluid overload on 1/8/14, 1/15/14, and 5/30/14. She was hospitalized for electrolyte & fluid disorder on 3/3/14 and 3/10/14. Further, records were reviewed for Patient #2's treatments from 5/3 -	V 541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 14 6/3/14. Eleven of 13 treatment records showed Patient #2 did not achieve her EDW during treatment. c. Anemia Management - Patient #2's POC showed a Hgb value of 9.2, with a goal of 10-11. A Tsat value of 28 was documented with a goal of 30-50. The plan to achieve the stated goal was "continue to monitor Hgb, ferritin & tsat." "Change ESA dose" was an option for achieving the anemia goal, but it was not included in Patient #2's POC. There was no expected outcome and there was no estimated timetable stated when the goal would be achieved or when the plan would be revisited and adjusted. d. Dialysis Access - This section showed Patient #2 had a tunneled jugular CVC. The goal for this section was "no catheter." It was noted Patient #2 was "unable - failed fistulas." The plan to achieve goal included "Continue or start access flow monitoring" and "refer to Vascular Access Plan and Tracking Form." There was no expected outcome or estimated timetable documented for Patient #2 to attain goal or for the IDT to revisit or adjust the plan. Patient Education: Diabetes - This section had boxes checked,indicating additional education was needed in these areas based on the comprehensive assessment, for the following: * Diabetes management & education referral * Diabetes management & education provided by Primary Care Physician * Diabetes Self - management of diet, footchecks, dental care, blood glucose monitoring, and diabetes meds. There were no goals and no plan to achieve	V 541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 541	Continued From page 15 specified goals. There was no expected outcome documented and no estimated timetable for Patient #2 to attain goals or for the IDT to revisit or adjust the plan. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager confirmed the POC for Patient #2 was not adequately developed. The facility failed to ensure Patient #2's POC comprehensively addressed her adequacy, fluid management, anemia status, or education needs.	V 541	**V 543: 494.90(a)(1) POC-MANAGE VOLUME STATUS** The Clinical Manager organized a mandatory staff training for all Registered Nurse staff to review the following: 2013 Liberty Dialysis Initial Physician Orders All staff will complete training on 6/30/14 and 7/1/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review.	7/7/14
V 543	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status; This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure POCs were implemented by addressing volume status for 2 of 4 ICHD patients (Patients #2 and #4) whose treatment records were reviewed. This failure resulted in patients not attaining their prescribed dry weight and being put at risk of complications resulting from fluid overload. Findings include: 1. Liberty Dialysis Initial Physician Orders for Hemodialysis, dated 2/6/2013, stated "Patients who are 2 kg or more above EDW post treatment will be offered a 4th treatment for the week." a. Patient #2 was a 27 year old ICHD patient. Her dialysis prescription included treatment four	V 543	Starting 6/30/14, the CM will complete weekly treatment sheet documentation audits to ensure that patients who are 2kg or more above his/her EDW post treatment will be offered an additional treatment. These audits will be completed weekly for 4 weeks. Audit results will be presented to the Governing Body by the CM starting July 3, 2014, at the weekly Governing Body Meeting. Audit results will, also, be presented to the QAI team beginning at the July meeting scheduled for 7/27/2014. Based on the audit results, the QAI team will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 543	Continued From page 16 times a week and her EDW was 52 - 53 kg. Thirteen treatment records from 5/3/14 - 6/3/14 were reviewed. Eleven of the thirteen records indicated Patient #2 did not achieve her EDW + 2 kg as follows: Date / Prescribed EDW / Actual EDW 5/3/14 53 kg 55.3 kg 5/8/14 53 kg 56 kg 5/13/14 52 kg 57 kg 5/19/14 53 kg 56.1 kg 5/20/14 52 kg 55.2 kg 5/22/14 52 kg 58 kg 5/24/14 52 kg 57.1 kg 5/27/14 52 kg 55.2 kg 5/29/14 52 kg 57.3 kg 6/2/14 53 kg 56.2 kg 6/3/14 52 kg 54.95 kg There was no documentation present indicating Patient #2 had been offered extra treatment time to remove excess fluid. Additionally, Patient #2 was hospitalized on 5/30/14 with a diagnosis of fluid overload. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager confirmed there was no documentation offering Patient #2 extra treatment time to remove fluid. b. Patient #4 was a 71 year old ICHD patient. Her unstable hemodialysis POC, dated 5/22/14, documented her EDW as 64.5 kg with a statement that her EDW "may be too high, frequently leaves under EDW." On the same date, 5/22/14, a comprehensive physician rounding note for Patient #4 stated "she is grossly fluid overloaded all the time."	V 543	make a determination as to the frequency of the audits moving forward. Once the QAI team has seen demonstrated improvement, the audit frequency may be decreased. The Clinical Manager is responsible to review analyze and trend the results of all audits and present to the QAI committee for review and oversight. The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 543	Continued From page 17 It was unclear which note was accurate and there was no change made to Patient #4's EDW as a result of either of the notes. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager confirmed there was conflicting documentation related to Patient #4's fluid status. She could not provide any clarifying information. The facility failed to address fluid status for Patients #2 and #4.	V 543		
V 557	494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an initial POC was developed and implemented in a timely manner for 1 of 4 ICHD patients (Patient #10,) whose records were reviewed. This failure created the potential for the patient's needs to remain unaddressed. Findings include: Patient #10 was a 65 year old male who was a Home Therapy Program patient, performing PD until 3/12/14. His PD catheter stopped functioning as a result of infection and he began in center hemodialysis, three times a week, on 3/13/14. He was hospitalized two times, resulting in missed treatments in-center on 4/5/14 and	V 557	**V 557: 494.90(b)(2) POC-INITIAL IMPLEMENTED-30 DAYS/13 TX** The Clinical Manager organized a mandatory staff training for all Registered Nurses, MSW, and RD staff to review the following: CIA/POC Tracker All staff will complete training on 6/30/14 and 7/1/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review. The CIA/POC Tracker will be implemented on 7/1/2014. The CM will be responsible for implementing and updating the tracker, including patients that change modality.	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 557	Continued From page 18 5/6/14. Patient #10's record documented an initial hemodialysis POC, dated and signed 4/29/14. This reflected the completion of Patient #10's POC after 19 in-center treatments rather than the required 13 in-center treatments, as well as a lapsed time of 48 calendar days rather than the required 30 calendar days. In an interview on 6/10/14 at 11:00 A.M., the Clinic Manager said the facility had considered Patient #10 to be in the PD program with "hemo back-up" until 4/10/14 when he was officially transferred to the hemodialysis modality. She said this was a misunderstanding by dialysis staff that seemed to be generated by corporate billing policies. She agreed that the timeframe for assessment and development of Patient #10's POC began on the first day of his hemodialysis treatments. Initial assessment and POC development was not done in a timely manner for Patient #10.	V 557	The CM will present the tracker to the QAI committee on a monthly basis. The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	
V 638	494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE The dialysis facility must continuously monitor its performance, take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI committee meeting minutes, it was determined the facility failed to ensure remedial actions were	V 638	**V638: 494.110(b) QAPI-MONITOR/ACT/TRACK/SUSTAIN IMPROVE** A new adequacy action plan was developed and implemented on 6/30/14 to ensure specific actions, with timelines, are taken to meet the adequacy facility goal by the CM and reviewed by the Director of Operations. The QAI Committee will review the action plan monthly beginning July 27, 2014, to ensure the plan is being followed and make adjustments as needed.	7/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 638	Continued From page 19 taken to sustain improved performance of ICHD patient adequacies. This failure had the potential to impact all patients through decreased outcomes. Findings include: 1. QAPI committee meeting minutes were reviewed for 13 months, from 4/2013 - 4/2014. A section of data collection reviewed was titled "Patient Outcomes, ICHD Adequacy." This section of the QAPI program reported the percentage of ICHD patients who had attained the MAT adequacy target noted by a Kt/V > 1.2. Each of the thirteen months of findings stated the facility goal was to "achieve FMS (corporate) goal within 3 months." Each of the thirteen months of findings stated the FMS (corporate) goal had not been met. An action plan was started in April, 2013. The plan included: * "CM will investigate process that is currently being used to follow up on labs." * "CM will review outliers to determine what changes if any need to occur, and work with physician and medical director to make needed alterations to treatment prescriptions." * "CM will review with staff proper lab draw technique." * "Increase BFR to 450 from 400 and increase DFR to 800 from 600." * "Increase size of dialyzer to 180NR from 160NR." Data collection included the following percentage of ICHD patients who had achieved the adequacy goal during the month: 4/2013 - 88.1%	V 638	The QAI Committee is responsible to review/analyze all data including monitoring results for adequacy including trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 638	Continued From page 20 5/2013 - 86.5% The action plan was adjusted in May, 2013 to include: * "[Physician's name] to order 14 gauge needles." * "BFR of 550 on all patients not meeting goal." Data collection included the following percentage of ICHD patients who had achieved the adequacy goal during the month: 6/2013 - 87.2% 7/2013 - 91.1% 8/2013 - 95.7% 9/2013 - 93.5% 10/2013 - 94% 11/2013 - 92.2% 2/2013 - 92.5% 1/2014 - 98% 2/2014 - 94.7% 3/2014 - 93.1% 4/2014 - 89.5% No further adjustments were made to the action plan for ten months from 5/2013 through 4/2014. The facility goal was not met during the time period and declines in the percentage of patients not attaining adequacy were seen for five months during that period including 9/2013, 11/2013, 2/2014, 3/2014, and 4/2014. The ICHD patient adequacy goal was not attained and improvement was not sustained with an effective action plan. Adequacy had declined to the prior year's level without being addressed. In an interview on 6/10/14 at 9:00 A.M., the Clinic Manager confirmed no adjustments were made to the action plan in response to decreasing adequacy for five months or in response to the	V 638		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY 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 638	Continued From page 21 facility's goal having not been met for thirteen months. The facility failed to ensure an effective, data driven QAPI action plan was maintained to ensure improvement goals were attained and sustained over time.	V 638	**V 751: 494.180 GOV-ID GOV BODY W/FULL AUTHORITH/RESPONSE** The Clinical Manager organized a mandatory staff training for all direct patient care staff to review the following procedure:	7/17/14
V 751	494.180 GOV-ID GOV BODY W/FULL AUTHORITY/RESPONS The ESRD facility is under the control of an identifiable governing body, or designated person(s) with full legal authority and responsibility for the governance and operation of the facility. The governing body adopts and enforces rules and regulations relative to its own governance and to the health care and safety of patients, to the protection of the patients ' personal and property rights, and to the general operation of the facility. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure drug labeling procedures were adopted and enforced in accordance with accepted standards of practice for 1 of 4 patients (Patient #11) whose pre-dialysis care was observed. This failure resulted in the potential for inappropriate medication administration. Findings include: 1. The Joint Commission National Patient Safety Goals, 2007, stated medication safety included the labeling of all medications, syringes, or other solutions. During observation on 6/02/14 at approximately 10:45 A.M., a PCT was observed at station #2	V 751	FMC-CS-IC-I-120-040A Medication Preparation & Administration Policy FMC-CS-IC-I-120-040C Medication Preparation & Administration Procedure All staff completed training on 6/12/14. An attendance form for acknowledgement of the training has been signed by each staff member and available in the facility for review. Additionally, beginning 6/30/14 audits utilizing the Medication Preparation and Administration audit tool will be conducted twice a week for four (4) weeks to monitor the effect of staff re-education and staff compliance. Audit results will be shared with the staff to review progress and address root causes of any observed non-compliance. Noncompliance will be addressed by the Clinical Manager including re-education and corrective action as appropriate, Documentation will be available in the facility for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132512	A. BUILDING _____ B. WING _____	06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS MERIDIAN	3525 E LOUISE DR, SUITE 100 MERIDIAN, ID 83642

(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 751	Continued From page 22 preparing Patient #11's left upper extremity access for cannulation prior to dialysis. Two unmarked syringes, containing a clear liquid, were present on the chairside table. The PCT subcutaneously (under the skin) injected the clear liquid into two separate areas of Patient #11's dialysis access. During the observation, the PCT and RN were interviewed. When asked, the PCT, stated the syringes were filled with Lidocaine (a local anesthetic). Further, RN stated labels were available for the Lidocaine syringes but they had not been used. The Clinic Manager was interviewed on 6/10/14 at 9:15 A.M. She confirmed medications drawn into a syringe need to be labeled. The facility failed to ensure drug labeling procedures were adopted and enforced in accordance with accepted standards of practice.	V 751	Audit results will be presented to the QAI team beginning at the July meeting scheduled for 7/27/14. Based on the audit results, the QAI team will make a determination as to the frequency of the audits moving forward. Once the QAI team has seen demonstrated improvement, the audit frequency may be decreased. The Clinical Manager is responsible to review analyze and trend the results of all audits and present to the QAI committee for review and oversight. The QAI Committee is responsible to review/analyze all data including monitoring results for issues and trends, provide oversight to the development or revision of the Plan of Action being taken and ensure resolution is occurring and is sustained.	