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: 7000 1670 0011 3315 1811

August 15, 2014

Lari Storro, Administrator
Liberty Dialysis Sandpoint
1210 Washington Ave
Sandpoint, ID 83864

RE: Liberty Dialysis Sandpoint, Provider #132522

Dear Ms. Storro:

Based on the survey completed at Liberty Dialysis Sandpoint, on August 1, 2014, by our staff, we have determined Liberty Dialysis Sandpoint is out of compliance with the Medicare ESRD Condition for Coverage of **CFC-Patient Plan of 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 Sandpoint, 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 submitting 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 September 15, 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 September 5, 2014.

Please complete your Allegation of Compliance/Plan of Correction and submit to this office by **August 28, 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

Fresenius Medical Services

August 26th, 2014

State of Idaho
Department of Health and Welfare
Division of Licensing & Certification
PO Box 83720
Boise, Idaho
83720-0009

Re: FMC-Liberty Dialysis Sandpoint
CMS Certification Number (CCN): 132522

To Whom It May Concern:

This letter is in response to the Idaho Department of Health & Welfare letter to facility management dated August 15th, 2014 regarding the Recertification survey dated 08/01/2014. It is to provide credible allegation that the deficiencies cited as a result of the survey have been or will be corrected by 08/25/2014 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 Sandpoint Dialysis and Fresenius Medical Care-North America take seriously their responsibility to ensure that the Liberty Sandpoint 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 08/25/2014 of the requirements as noted within the Comprehensive Intra-disciplinary Assessment and Plan of Care Policy with the direction to provide an in-service 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 in-service and reeducation was presented and all IDT members completed training no later than 08/25/2014. A sign-in sheet is available at the facility for review.
- The staff and monitoring efforts will focus on completion of patient plan of cares, monitoring patients during treatment, patient receiving services and fluid volume status.

The Medical Director of the facility acknowledges his/her role to ensure that all IDT members adhere to the requirements of the Condition for Coverage of CFC-Patient Plan of Care (42CFR 494.90). 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 well as the company's local, regional and corporate support for facility operations; the FMC-Liberty Dialysis - Sandpoint facility is operating in compliance with the Plan of Correction for the Idaho Department of Health's Survey findings.

If you have questions, I can be reached at 208-263-4488. I look forward to your response regarding the above stated requests and thank you for your consideration.

Sincerely,

Matt Sanchez
Area Manager, North Idaho Area
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
	132522	A. BUILDING _____ B. WING _____	08/01/2014

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LIBERTY DIALYSIS SANDPOINT	1210 WASHINGTON AVE SANDPOINT, ID 83864

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification survey of your ESRD facility from 7/28/14 - 8/1/14. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: BP - Blood pressure CCHT - Certified Clinical Hemodialysis Technician EDW - Estimated Dry Weight ICHD - Incenter Hemodialysis kg - kilogram mm/Hg - millimeter of mercury PA - Physician Assistant PCT - Patient Care Technician POC - Plan of Care re - about, concerning, regarding Rx - Prescription Wt - weight UF - Ultrafiltration	V 000	Initial Comments The Governing Body of this facility takes seriously its responsibility to govern the everyday operations at the facility in such a manner as to ensure the quality of dialysis treatments and operations as well as the health and safety of each patient. As such, the Governing Body, which includes the Director of Operations, Clinical Manager, and Medical Director met on **August 25th, 2014**, to review the deficiencies received from the Department of Health Services and to participate in the development of the following Plan of Correction. The Governing Body will maintain oversight of the progress of the Plan of Correction through the monthly QAI Committee meetings. RECEIVED AUG 28 2014 FACILITY STANDARDS	08/25/2014
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 a patient's right to receive care as outlined in his	V 463	**494.70(a)(12) PR-Receive Services Outlined in POC** The Clinical Manager and the education coordinator organized mandatory staff training for all DPC and IDT staff to review and sign acknowledgement form referencing education on the following policies and procedures: • FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy • FMS-CS-IC-I-110-125D1 Comprehensive Interdisciplinary Assessment	08/25/2014

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

Area Manager — 8-27-14

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.

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V 463	Continued From page 1 POC was upheld for 1 of 5 ICHD patients (Patient #2) whose treatment records were reviewed. This resulted in a patient not dialyzing for his prescribed length of time and being left at risk for complications of inadequate dialysis. Findings include: Patient #2 was a 26 year old male who had been dialyzing at the facility since 3/1/13. His dialysis orders stated he was to receive treatment three times a week for 210 minutes. Seventeen treatment records were reviewed from 6/20/14 - 7/25/14 with the following results: Date — RX Time — Actual Time 6/23/14 — 210 min. — 173 min. 6/25/14 — 210 min. — 181 min. 6/27/14 — 210 min. — 190 min. 6/30/14 — 210 min. — 193 min. 7/2/14 — 210 min. — 172 min. 7/4/14 — 210 min. — 205 min. 7/7/14 — 210 min. — 187 min. 7/11/14 — 210 min. — 203 min. 7/14/14 — 210 min. — 170 min. 7/16/14 — 210 min. — 157 min. 7/23/14 — 210 min. — 162 min. 7/25/14 — 210 min. — 132 min. Patient #2 did not receive his prescribed treatment time during 12 of the 17 treatments reviewed, for a total lost time of 6 hours and 35 minutes. In an interview on 7/29/14 at 4:00 P.M., the nurse manager said if extra treatment time was offered to patients it should be documented on the treatment sheet.	V 463	• FMS-CS-IC-I-110-125D2 Patient Plan of Care All applicable staff will have the completed training by 8/25/2014. An Acknowledgement of the training will be signed by each staff member and available in the facility for review. Additionally, beginning 8/4/2014 medical record audits utilizing the QAI medical record audit tool will be conducted weekly to monitor the effect of staff re-education and staff compliance with patients meeting their prescribed time. Audit results will be reviewed with the staff to monitor 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 August meeting scheduled for 8/25/2014. Based on the audit results, the Goveruing Body will make a determination as to the frequency of the audits moving forward. Once the Governing Body 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 Area Manager as a facilitator and member of the QAI Committee is responsible to ensure medical record audits are completed, reviewed and trended during the QAI meeting and presented to Governing Body for continual oversight. The QAI Committee is responsible to review/analyze all data including monitoring	

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V 463	Continued From page 2 Documentation showed Patient #2 had been offered replacement treatment time on only two occasions. Patient #2 refused extra treatment time offered by nursing on 6/30/14. An order was written by the PA for additional treatment time, for removal of excess fluid, on 7/15/14. Patient #2 attended this treatment. Additionally, a Provider Rounding Note written by the PA, dated 7/21/14, stated "No further extra runs if he is coming off early." In an interview on 7/30/14 at 4:00 P.M., the nurse confirmed the lost time and documented extra treatments for Patient #2. The facility failed to ensure Patient #2 received his prescribed dialysis treatment time.	V 463	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 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 update or implement comprehensive patient POCs for 6 of 6 patients (Patient #1 - #6) 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 V543 as it relates to the facility's failure to ensure patients' volume status was managed and patients' blood pressures were	V 540	**494.90 CFC-Patient Plan of Care** The Governing Body acknowledges its responsibility to ensure that Liberty Dialysis Sandpoint has a process implemented to ensure that every patient has a timely, complete and current Comprehensive Assessment and Plan of Care completed by all members of the IDT members which is available within their medical record and meets all criteria. The Governing Body also acknowledges its responsibility to ensure patients are receiving their prescribed treatment and are monitored according to FMS policy. The Governing Body, which includes the facility's Medical Director, Clinical Manager, Area Manager and Regional Vice President reviewed the SOD on 08/25/2014 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. The Governing Body will meet weekly beginning 08/25/2014 to monitor the progress of the Plan of Correction until the Condition level deficiencies are lifted then will resume 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. • 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	**08/26/2014**

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V 540	Continued From page 3 adequately monitored. 3. Refer to V558 as it relates to the facility's failure to ensure a comprehensive POC was updated annually for all home therapy patients.	V 540	providing resolution of the issues • The Area Manager 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. • The Governing Body, at its meeting of 08/26/2014, designated the Regional Quality Manager to serve as Plan of Correction Monitor and provide additional oversight. The Regional Quality Manager will actively participate in QAI and Governing Body meetings - either personally or via conference call - and submit a status report at each of the referenced Governing Body meetings with a copy to the RVP. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance oversight role. Duration of this oversight will be determined by the Governing Body. • 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. • The responses provided for V Tag' s V463, V543 and V558 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 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 5 ICHD patients (Patients #2 and #4) and failed to ensure blood pressure monitoring was done for 4 of 5 ICHD patients (Patients #2 - #5.) These failures resulted in patients not attaining their prescribed dry weight and being put at risk of complications resulting from fluid overload, hypotension, and hypertension. Findings include: 1. Volume status was not managed for two patients as follows: A policy titled Nursing Supervision and Delegation, dated 9/25/13, stated "Any post treatment weight with a variance from the estimated dry weight of 0.5 kg" should be referred to the charge nurse for further assessment. a. Patient #2 was a 26 year old male who had been dialyzing at the facility since 3/1/13. His dialysis prescription included a EDW of 82 kg. Seventeen treatment sheets from 6/20/14 -	V 543	**494.90(a)(1) POC-Manage Volume Status** The Clinical Manager and the education coordinator will organize mandatory staff training for all DPC and IDT staff to review and sign acknowledgement form	08/25/2014

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V 543	Continued From page 4 7/25/14 were reviewed with the following results: Date EDW Post wt. 6/20/14 82 kg 88 kg 6/23/14 82 kg 84.8 kg 6/25/14 82 kg 84.5 kg 6/27/14 82 kg 84.5 kg 6/30/14 82 kg 86.1 kg 7/02/14 82 kg 86.5 kg 7/04/14 82 kg 86.0 kg 7/07/14 82 kg 88.8 kg 7/09/14 82 kg 86.2 kg 7/11/14 82 kg 86.2 kg 7/14/14 82 kg 87.6 kg 7/15/14 82 kg 85.8 kg 7/16/14 82 kg 84.5 kg 7/18/14 82 kg 83.4 kg 7/21/14 82 kg 84.3 kg 7/23/14 82 kg 85.0 kg 7/25/14 82 kg 86.5 kg Patient #2 did not attain his prescribed EDW during 17 of 17 treatments reviewed. Documentation showed Patient #2's fluid overload was addressed in 8 of 17 treatments. Extra treatment time was offered two times and six times repetitive, but ineffective, education was noted as "advised re fluid" and "seek medical help if needed." In an interview on 7/29/14 at 4:00 P.M., the nurse manager confirmed Patient #2's post dialysis weights and nursing documentation. b. Patient #4 was a 57 year old male who had been dialyzing at the facility since 6/17/09. His dialysis prescription included a EDW of 103.5 kg. Twelve treatment sheets from 6/30/14 - 7/25/14	V 543	referencing education on the following policies and procedures: • FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy • FMS-CS-IC-I-110-125D1 Comprehensive Interdisciplinary Assessment • FMS-CS-IC-I-110-125D2 Patient Plan of Care • FMS-CS-IC-I-110-149A Nursing Supervision and Delegation Policy • FMS-CS-IC-I-110-133A Monitoring During Patient Treatment Policy All staff will have completed training by 8/25/2014. An Acknowledgement of the training will be signed by each staff member and available in the facility for review. Additionally, beginning 8/14/2014 medical record audits utilizing the QAI medical record audit tool will be conducted monthly 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.	

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V 543	Continued From page 5 were reviewed with the following results: Date EDW Post wt. 6/30/14 103.5 kg 104.7 kg 7/02/14 103.5 kg 103.3 kg 7/04/14 103.5 kg 104.1 kg 7/07/14 103.5 kg 106.3 kg 7/09/14 103.5 kg 106.5 kg 7/11/14 103.5 kg 105.5 kg 7/14/14 103.5 kg 106.1 kg 7/16/14 103.5 kg 107.4 kg 7/18/14 103.5 kg 106.0 kg 7/21/14 103.5 kg 106.8 kg 7/23/14 103.5 kg 106.3 kg 7/25/14 103.5 kg 106.2 kg Patient #4 did not attain his prescribed EDW during 11 of 12 treatments reviewed. Documentation showed Patient #4's fluid overload was addressed in 9 of 12 treatments with repetitive, but ineffective, education noted as "advised re fluid." There was no documentation extra treatment time was offered to Patient #4 for fluid removal during the 4 week period reviewed. In an interview on 7/29/14 at 4:00 P.M., the nurse manager confirmed Patient #4's post dialysis weights and nursing documentation. The facility failed to ensure volume status was managed for Patients #2 and #4. 2. Four patients were not adequately monitored, per facility policy, during treatment. A policy titled Patient Monitoring During Patient Treatment, dated 7/4/12, stated "Vital signs will be monitored at the initiation of dialysis and every	V 543	Audit results will be presented to the QAI team beginning at the August meeting scheduled for 8/25/2014. Based on the audit results, the QAI Committee 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 Area Manager as a facilitator and member of the QAI Committee is responsible to ensure medical record audits are completed, reviewed and trended during the QAI meeting and presented to Governing Body for continual 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.	

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V 543	Continued From page 6 30 minutes, or more frequently, as needed." A second policy titled Nursing Supervision and Delegation instructed directed care staff to refer patients to the charge nurse for further assessment "if B/P less than or equal to 100 mm/Hg systolic during treatment." a. Patient #2 was a 26 year old male who had been dialyzing at the facility since 3/1/13. Twelve treatment sheets from 6/20/14 - 7/21/14 were reviewed. Patient #2 did not have vital signs monitored, per policy, for 43% of his treatment time as follows: 6/20/14 - No vital signs were recorded from 1015 until 1204 or from 1234 until 1335. 6/23/14 - Vital signs were not taken from 1030 until 1235, and from 1235 until 1322. 6/27/14 - No vitals were taken from 1043 until 1208 and again from 1208 until 1336. 6/30/14 - Patient #2 had a 3 hour 13 minute dialysis treatment. Vitals were taken only two times, at the initiation of treatment, (1015,) and at the close of treatment, (1323.) 7/2/14 - Vitals were recorded two times during a 2 hour 52 minute treatment, at the initiation of treatment, (1023) and again 5 minutes prior to the end of treatment (1305.) 7/4/14 - No vital signs were taken from 1011 until 1133 and again from 1133 until 1308. 7/9/14 - No vital signs were taken from 0956 until 1133, from 1133 until 1228, and from 1228 until	V 543		

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V 543	Continued From page 7 the end of treatment at 1330. 7/11/14 - Vitals were not taken from 1003 until 1133. 7/14/14 - No vitals were taken from 1205 until 1313. 7/16/14 - Vitals were not taken from 0951 until 1102 and from 1102 until 1206. 7/18/14 - No vitals were taken from 1003 until 1217. 7/21/14 - Vitals were not taken from 0947 until 1108 and again from 1134 until 1233. b. Patient #4 was a 57 year old male who had been dialyzing at the facility since 6/17/09. Twelve treatment sheets from 6/20/14 - 7/28/14 were reviewed. Patient #4 did not have vital signs monitored, per policy, for 30% of his treatment time as follows: 6/20/14 - Treatment was started at 0544. Initial vital signs were not taken until 0559. Follow up vitals were not done until 0655. 6/23/14 - Vitals were taken at 0735. Follow up vitals were recorded at 0830. Patient #4's BP at 0903 was 92/52. It was not taken again until treatment ended at 1013. No documentation was present showing the RN was notified of low BP. 6/25/14 - Patient #4's BP was 99/49 at 0926. No documentation was present showing the RN was notified of low BP. Vitals were not taken again until treatment ended at 1019.	V 543		

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V 543	Continued From page 8 7/4/14 - Vital signs were taken when treatment was initiated at 0544 and not recorded again until 0708. Vitals were recorded at 0831 and not again until the end of treatment at 1015. 7/9/14 - Treatment started at 0550 and initial vital signs were not taken until 0618. No further vitals were recorded until 0738. Vital signs were taken at 0911 and not again until the end of treatment at 1025. 7/11/14 - Vital signs were taken at 0920 and not taken again until 1052 when Patient #4's BP was 84/54. 7/14/14 - Patient #4's vital signs were taken at 0832 showing a BP of 92/55. No further vitals were recorded until the end of treatment at 1010. No documentation was present showing the RN was notified of low BP. 7/16/14 - Treatment was started at 0545 but initial vitals were not taken until 0629. No vital signs were recorded from 0831 until 1005. 7/21/14 - Treatment was started at 0545 but initial vital signs were not taken until 0612. Follow up vitals were taken at 0634 and not again until 0801, and no vitals were recorded from 0835 until 0954. 7/23/14 - Treatment was started at 0720 but no vital signs were recorded until 0847. Again, no vitals were taken from 0905 until 1052. Patient #4's BP had dropped from 131/69 to 101/53 during this period. 7/25/14 - Patient #4's BP was 101/46 at 0925. His UF rate was decreased at this time. No further	V 543		

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	132522	A. BUILDING _____ B. WING _____	08/01/2014

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V 543	Continued From page 9 vitals were taken until 1015 at which time Patient #4's BP was 84/46. 7/28/14 - Treatment was started at 0555 but initial vitals were not taken until 0632. No vitals were taken from 0837 until 1001 at which time Patient #4's BP was 100/55. No documentation was present showing the RN was notified of low BP. c. Patient #3 was a 77 year old female who had been dialyzing at the facility since 8/19/13. Fourteen treatment sheets from 6/21/14 - 7/26/14 were reviewed. Patient #3 did not have vital signs monitored, per policy, for 32% of her treatment time as follows: 6/21/14 - BP was recorded as 97/50 at 1241. No documentation was present showing the RN was notified of low BP. Vitals were not taken again until 1332 at which time Patient #3's BP was 73/37. Again, no documentation was present showing the RN was notified of low BP.. Vitals were not taken again until 1431 at which time Patient #3's BP was 90/49. No documentation was present showing the RN was notified of low BP. 6/24/14 - Initial vitals were taken at 1141 with no follow up vitals until 1232. No vitals were taken from 1232 until 1338. Vitals taken at 1404 showed Patient #3's BP was 85/42. No documentation was present showing the RN was notified of low BP and no further vitals were monitored until the end of treatment at 1443 that showed a continued low BP of 84/49. 6/28/14 - No vital signs were recorded from 1203 until 1306. Patient #3's BP had dropped from 143/78 to 108/57 during that period. A 1403 BP	V 543		

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V 543	Continued From page 10 reading showed 94/55. No documentation was present showing the RN was notified of low BP. 7/1/14 - Treatment was initiated and vitals were recorded at 1159. No further vitals were taken until 1256. 7/3/14 - No vital signs were recorded from 1159 until 1310. Patient #3's BP had dropped from 154/86 to 94/55. No documentation was present showing the RN was notified of low BP. At 1331 BP was recorded as 87/53. No documentation was present showing the RN was notified of low BP. No further vitals were taken until the end of treatment at 1423. 7/5/14 - Treatment was started at 1130. Initial vital signs were not taken until 1202. No vitals were recorded from 1202 until 1305 or from 1305 until the end of treatment at 1430. 7/8/14 - No vital signs were recorded from 1132 until 1232 at which time Patient #3's BP dropped from 149/76 to 98/62. No documentation was present showing the RN was notified of low BP. Again no vitals were recorded from 1304 until the end of treatment at 1422. 7/10/14 - No vital signs were recorded from 1127 until 1305. 7/15/14 - No vital signs were taken from 1237 until 1345 at which time Patient #3's BP had dropped from 104/72 to 69/45. 7/17/14 - Treatment started at 1142 but initial vital signs were not taken until 1230. 7/19/14 - No vital signs were taken from 1136	V 543		

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V 543	Continued From page 11 until 1235. Patient #3's BP dropped from 155/86 to 102/56 during this period. Her BP was 96/61 at 1403 and no documentation was present showing the RN was notified of low BP. No further vitals were taken until the end of treatment at 1444. 7/22/14 - Treatment started at 1132 but initial vitals were not taken until 1201. No further vitals were recorded until 1334. Patient #3's BP dropped from 151/79 to 89/53 during this period and no documentation was present showing the RN was notified of low BP. 7/24/14 - Treatment was started at 1145. Initial vital signs were recorded at 1314 at which time Patient #3's BP was 88/55. 7/26/14 - No vitals were recorded from 1219 until 1316. Patient #3's BP had dropped from 135/69 to 106/27. No vitals were taken from 1316 until 1402 when her BP was 85/48. No documentation was present showing the RN was notified of low BP. At 1439 Patient #3's BP was 91/52. No documentation was present showing the RN was notified of low BP and no further BP was taken until the end of treatment at 1505. d. Patient #5 was a 79 year old male who had been dialyzing at the facility since 2/16/11. Twelve treatment sheets from 6/23/14 - 7/25/14 were reviewed. Patient #5 did not have vital signs monitored, per policy, for 34% of his treatment time as follows: 6/23/14 - Vital signs were not taken from 0632 until 0802, from 0802 until 0904, and from 0904 until treatment was ended at 1026. 6/27/14 - Initial vitals were taken at 0630. No	V 543		

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V 543	Continued From page 12 further vitals were taken until the end of treatment at 1015. 6/30/14 - Vitals were not taken from 0702 until 0841 or from 0903 until the end of treatment at 1018. 7/2/14 - Vital signs were not taken from 0632 until 0750. 7/4/14 - No vitals were taken from 0844 until the end of treatment at 1021. 7/9/14 - Vitals were not taken from 0731 until 0830 or from 0830 until 1003. 7/11/14 - No vitals were taken from 0930 until the end of treatment at 1020. 7/14/14 - No vitals were recorded from 0832 until 0951. 7/16/14 - Patient #5's initial BP at 0631 was 98/56. No documentation was present showing the RN was notified of low BP and no further BP was taken until 0736. No vitals were taken from 0858 until the end of treatment at 1015. 7/18/14 - Vitals were not monitored from 0626 until 0731, from 0731 until 0825, or from 0825 until the end of treatment at 1013. 7/23/14 - Vitals were not monitored from 0924 until 1025. 7/25/14 - No vitals were recorded from 0829 until 1003. In an interview on 7/31/14 at 8:30 A.M., the nurse	V 543		

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V 543	Continued From page 13 manager confirmed the lack of monitoring for Patients #2 - #5. She said this issue was addressed at a staff meeting on 6/18/14 and she was surprised the practice was continuing. The facility failed to ensure Patients #2 - #5 were monitored according to policy.	V 543	**494.90(b)(2) POC-Implement Update-15 Days Pt Assess** The Clinical Manager and the education coordinator organized mandatory staff training for all IDT staff to review and sign acknowledgement form referencing education on the following policies and procedures: • FMS-CS-IC-I-110-125A Comprehensive Interdisciplinary Assessment and Plan of Care Policy • FMS-CS-IC-I-110-125D1 Comprehensive Interdisciplinary Assessment • FMS-CS-IC-I-110-125D2 Patient Plan of Care All staff will have completed training by 8/25/2014. An Acknowledgement of the training will be signed by each staff member and available in the facility for review. A Follow-Up POC tracking tool has been developed and in place on 8/18/2014 to ensure that the POC is implemented and updated per CMS requirements and Fresenius Policy and Procedure. Patient #6 had a compete CIA / POC developed by the Home Therapies IDT and implemented by 8/25/2014. Additionally, beginning 8/4/2014 medical record audits will be conducted monthly to monitor the completeness of the medical record as per the QAI calendar. Focus areas of the audit review will identify patients who are not meeting their prescribed treatment time. Audit results will be reviewed with the staff to monitor completeness 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 August meeting scheduled for 8/25/2014. The Clinical Manager is responsible to review analyze and trend the results of all	08/25/2014
V 558	494.90(b)(2) POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d). This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure an annual POC was developed and implemented for 1 of 1 home therapy patient (Patient #6) whose record was reviewed. This failure created the potential for the patient's needs to remain unaddressed. Findings include: Patient #6 was a 35 year old male who had been dialyzing at the facility since 11/29/10. Review of his record showed the most recent POC for Patient #6 was developed and implemented in February 2013. In an interview on 7/30/14 at 2:00 P.M., the home therapies nurse manager said she was sure a more recent POC had been developed for Patient #6 but she was unable to locate it, and no POC for Patient #6 was found before survey ended. The facility failed to develop and implement an	V 558		

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V 558	Continued From page 14 updated POC for Patient #6.	V 558	audits and present to the QAI committee for review and oversight. The Area Manager as a facilitator and member of the QAI Committee is responsible to ensure medical record audits are completed, reviewed and trended during the QAI meetings. 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. Based on the audit results, the Governing Body will make a determination as to the frequency of the audits moving forward. Once the Governing Body has seen demonstrated improvement, the audit frequency may be decreased.	
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 taken to sustain improved performance of ICHD patient monitoring. This failure had the potential to impact all ICHD patients by putting them at risk of undetected intradialytic complications. Findings include: QAPI meeting minutes and data was reviewed from 7/2013 - 7/2014. Meeting minutes dated 6/16/14 reflected review of May, 2014 data. Section 4: "Medical Record Review" documented "Medical record review noted that 30 min patient checks are not always completed within 30 minute window. Staff shares that at times they are busy working with other patients and are unable to physically be at each patients [sic] side to document. BP's set to take every 20 minutes, and patients are visually observed. Also noted that changes in patient status and treatment provided is not always documented in patient record. Plan: Discuss areas of concern with staff in next staff meeting. Will educate staff on importance of working together to ensure that 30 minute checks and patient changes are	V 638	**494.110(b) QAPI-Monitor/Act/Track/Sustain/Improve** The Governing Body directed the Clinical Manager to review / analyze / trend all of the medical record audits and report to the QAI committee. Audit results will be presented to the QAI team beginning at the August meeting scheduled for 8/25/2014. 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 Area Manager as a facilitator and member of the QAI Committee is responsible to ensure medical record audits are completed, reviewed and trended during the QAI meetings. 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. Based on the audit results, the Governing Body will make a determination as to the frequency of the audits moving forward. Once the Governing Body has seen demonstrated improvement, the audit frequency may be decreased.	**08/25/2014**

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V 638	Continued From page 15 accurately documented." In an interview on 7/30/14 at 4:00 P.M., the nurse manager stated she had done a chart audit in April, 2014 and had taken the monitoring concern to the QAPI meeting. When asked, she said she did not have quantitative results of the chart audit and had done no further audits to assess whether the QAPI improvement plan was positively affecting patient monitoring. Review of June, 2014 data showed there was no data to present and reassessment of patient monitoring was not addressed in the Medical Record Review section. The facility failed to ensure the QAPI committee tracked performance to ensure patient monitoring had improved.	V 638		
V 681	494.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY All dialysis facility staff must meet the applicable scope of practice board and licensure requirements in effect in the State in which they are employed. The dialysis facility's staff (employee or contractor) must meet the personnel qualifications and demonstrated competencies necessary to serve collectively the comprehensive needs of the patients. The dialysis facility's staff must have the ability to demonstrate and sustain the skills needed to perform the specific duties of their positions. This STANDARD is not met as evidenced by: Based on personnel record review, patient medical record review, and staff interview, it was	V 681	**494.140 PQ-Staff Lic as Req/Qual/Demo Competency** The Clinical Manager will request and verify that any staff member providing care in the facility will have a current clinical competency either in the facility or immediately available for staff that are assigned to another facility. This has been completed by 08/18/2014 on staff F-I. Additionally, beginning 8/11/2014 staff records audits utilizing the QAI personnel license and education tracking tools will be conducted monthly to monitor compliance and results will be reviewed with the QAPI committee according to the QAI calendar. Noncompliance will be addressed by the Clinical Manager to include resolution on any identified issues. Documentation will be available in the facility for review. Tracking results will be presented to the QAI committee beginning at the August meeting scheduled for 8/25/2014. Based on the results, the QAI committee will develop an action plan, if warranted. The Clinical Manager is responsible to oversee the qualifications of any and all staff providing care in the facility. The Area Manager as a facilitator and member of the QAI Committee is responsible to ensure that the QAI tracking tools are completed and up to date and that any identified concerns relavent to staff	08/25/2014

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V 681	Continued From page 16 determined the facility failed to ensure clinical competencies were demonstrated by 4 of 9 direct care staff (Staff F - I) whose personnel records were reviewed. Findings include: During patient treatment sheet reviews, 9 PCTs were identified by signature as having cared for facility patients during the time period 6/20/14 through 7/28/2014. When requested, personnel records, including competency demonstrations, were not available for Staff F - I . In an interview on 7/30/14 at 4:00 P.M., the nurse manager said Staff F - I were "borrowed" from another dialysis unit. She said she had not developed personnel files for these staff but she assumed the nurse manager of their home unit maintained current competency records. Current clinical competency demonstration was not ensured by the facility for four staff members who were providing direct patient care.	V 681	qualifications are addressed immediately. The QAI Committee will 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 694	494.140(e)(3) PQ-PCT-TRAINING PROGRAM CONTENT The training program must include the following subjects: (i) Principles of dialysis. (ii) Care of patients with kidney failure, including interpersonal skills. (iii) Dialysis procedures and documentation, including initiation, proper cannulation techniques, monitoring, and termination of dialysis. (iv) Possible complications of dialysis. (v) Water treatment and dialysate preparation. (vi) Infection control.	V 694	**494.140(e)(3) PQ-PCT-Training Program Content** The Clinical Manager will request and verify that any staff member providing care in the facility will have documentation that they have completed an approved training program either in the facility or immediately available for staff that are assigned to another facility. This has been completed by 08/18/2014 on staff F-I. Additionally, beginning 8/11/2014 staff records audits utilizing the QAI personnel license and education tracking tools will be conducted monthly to monitor compliance and results will be reviewed with the QAPI committee according to the QAI calendar. Noncompliance will be addressed by the Clinical Manager to include resolution on any identified issues. Documentation will be available in the facility for review. Tracking results will be presented to the QAI committee beginning at the August meeting scheduled for 8/25/2014. Based on the results, the QAI committee will develop an action plan, if warranted.	08/25/2014

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V 694	Continued From page 17 (vii) Safety. (viii) Dialyzer reprocessing, if applicable. This STANDARD is not met as evidenced by: Based on personnel record review, patient treatment sheet review, and staff interview it was determined the facility failed to ensure an approved training program had been completed by 4 of 6 direct care staff (Staff F - I) whose personnel records were reviewed. Findings include: During patient treatment sheet reviews, 9 PCTs were identified by signature as having cared for facility patients during the time period 6/20/14 through 7/28/2014. When requested, personnel records, documenting completion of an approved training program, were not available for Staff F - I. In an interview on 7/30/14 at 4:00 P.M., the nurse manager said Staff F - I were "borrowed" from another dialysis unit. She said she had not developed personnel files for these staff but she assumed the nurse manager of their home unit maintained documentation of training program completion. Documentation of an approved training program completion was not ensured by the facility for four staff members who were providing direct patient care.	V 694	The Clinical Manager is responsible to oversee the qualifications of any and all staff providing care in the facility. The Area Manager as a facilitator and member of the QAI Committee is responsible to ensure that the QAI tracking tools are completed and up to date and that any identified concerns relavent to staff qualifications are addressed immediately. The QAI Committee will 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 695	494.140(e)(4) PQ-PCT CERTIFIED Patient care dialysis technicians must- (4) Be certified under a State certification program or a national commercially available	V 695	**494.140(e)(4) PQ-PCT Certified** The Clinical Manager will request and verify that any staff member providing care in the facility will have a copy of their current certification (if applicable) either in the facility or immediately available for staff that are assigned to another facility. This has been completed by 08/18/2014 on staff F-I. Additionally, beginning 8/11/2014 staff records audits utilizing the QAI personnel license and education tracking tools will be conducted monthly to monitor	08/25/2014

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V 695	Continued From page 18 certification program, as follows- (i) For newly employed patient care technicians, within 18 months of being hired as a dialysis patient care technician; or (ii) For patient care technicians employed on October 14, 2008, within 18 months after such date. This STANDARD is not met as evidenced by: Based on personnel record review and staff interview it was determined the facility failed to ensure certification 1 of 4 direct care staff (Staff G) whose personnel record was reviewed. Findings include: During patient treatment sheet reviews, one direct care staff was identified by signature as having cared for facility patients during the time period 6/20/14 through 7/28/2014. The signature showed Staff G as being a CCHT. When requested, personnel records, documenting the certification of Staff G were unavailable. In an interview on 7/30/14 at 4:00 P.M., the nurse manager said Staff G was "borrowed" from another dialysis unit. She said she had not developed a personnel file for Staff G but she assumed the nurse manager of her home unit maintained documentation of certification. Documentation of certification was not ensured by the facility for one staff member who was providing direct patient care.	V 695	compliance and results will be reviewed with the QAPI committee according to the QAI calendar. Noncompliance will be addressed by the Clinical Manager to include resolution on any identified issues. Documentation will be available in the facility for review. Tracking results will be presented to the QAI committee beginning at the August meeting scheduled for 8/25/2014. Based on the results, the QAI committee will develop an action plan, if warranted. The Clinical Manager is responsible to oversee the qualifications of any and all staff providing care in the facility. The Area Manager as a facilitator and member of the QAI Committee is responsible to ensure that the QAI tracking tools are completed and up to date and that any identified concerns relevant to staff qualifications are addressed immediately.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 15, 2014

Lari Storro, Administrator
Liberty Dialysis Sandpoint
1210 Washington Ave
Sandpoint, ID 83864

RE: Liberty Dialysis Sandpoint, Provider #132522

Dear Ms. Storro:

On August 1, 2014, a complaint survey was conducted at Liberty Dialysis Sandpoint. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006551

Allegation #1: The facility's physical environment is poorly maintained, creating safety hazards for patients.

Findings #1: An unannounced visit was made to the facility from 7/28/14 - 8/1/14 with the following results:

Observations and staff interviews were completed. It was observed that the door between the lobby and the treatment floor was fully operable with a push button that was accessible by persons in wheelchairs. It was also observed the facility had a scale that was set flush in the floor. This scale was safely accessible by all persons whether ambulatory or in wheelchairs. In an interview on 7/29/14 at 1:00 P.M., the biomedical technician confirmed that his department was responsible for the general maintenance of the facility. Review of maintenance records showed the automatic lobby door had been inoperable on 6/20/14 due to a blown fuse. It was repaired immediately.

Records also showed the scale in the floor had been inoperable for a period of approximately 5 months. The biomedical technician explained that major renovations were necessary to install a new floor flush scale. The new scale was put into service on 7/24/14.

During the 5 month renovation period a portable scale had been used for patients to obtain pre and post dialysis weights. The portable scale was currently stored in a back room of the facility and was examined.

The portable scale was equipped with ramps on each side of the platform for ambulatory and wheelchair bound patients. Handrails were present, and all edges of the platform were marked with bright tape to denote uneven surfaces. The platform was large enough to accommodate both ambulatory patients and wheelchair bound patients. No patient safety issues were noted.

Because the door and the scale had been documented as being inoperable, the allegation was substantiated. However, the facility took immediate action to repair equipment failures while ensuring patient safety. Therefore, no deficient practice was identified.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Staff members do not observe infection control practices.

Findings #2: Direct patient care was observed for approximately eight hours from 7/28/14 - 7/31/14. During this time, staff were observed to clean dialysis stations after patient use and prepare the stations for the next patients. An appropriate bleach solution was used to wipe all chairs, tables, dialysis machines, and blood pressure cuffs. All used supplies were disposed of and no dried blood was noted to be left on any surfaces. Blood pressure cuffs occasionally fell to the floor during the cleaning process but were cleaned with bleach solution after contact with the floor.

No personal grooming was noted to occur on the treatment floor during observations.

No patients were noted to have excessive post dialysis access bleeding during observations. Three direct care staff were interviewed. All interviewed staff stated if post bleeding occurred the access dressing would be reinforced and the access extremity would be cleaned before the patient was discharged.

It could not be determined that the facility failed to ensure infection control practices were observed. Therefore, the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patient needs are not addressed by all staff members.

Findings #3: Patient care was observed for approximately eight hours from 7/28/14 - 7/31/14. Three patient care technicians stated that, while each staff was assigned to specific patients, staff cared for all patients as needed. One staff said "We all look around to see what needs to be done." During observations, staff were noted to initiate dialysis, discontinue dialysis, and provide care for patients, regardless of patient care assignments.

Additionally, treatment records, from 6/20/14 - 7/25/14, were reviewed for five patients. Signature verification showed multiple staff monitored patients during treatments.

It could not be determined that the facility failed to ensure patient needs were not addressed by all staff. Therefore, the allegation was unsubstantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Trish O'Hara

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TO/pmt