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
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PHONE 208-334-6626
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December 1, 2014

Shelby Wright, Administrator
Liberty Dialysis Caldwell
4620 Enterprise Way, Suite 101
Caldwell, ID 83605-6764

RE: Liberty Dialysis Caldwell, Provider #132523

Dear Ms. Wright:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Caldwell, which was conducted on November 21, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **December 14, 2014,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132523	A. BUILDING _____ B. WING _____	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS CALDWELL	4620 ENTERPRISE WAY, SUITE 101 CALDWELL, ID 83605

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V 000	INITIAL COMMENTS [CORE] The following deficiencies were cited during the recertification and complaint survey of your ESRD facility from 11/17/14 - 11/21/14. The surveyor conducting the survey was: Trish O'Hara, RN Acronyms used in this report include: BP - Blood Pressure CVC - Central Venous Catheter g/dl - grams per deciliter HHD - Home Hemodialysis ICHD - In-center Hemodialysis IDPN - Intradialytic Parenteral Nutrition IDT - Interdisciplinary Team KDOQI - Kidney Dialysis Outcome Quality Initiative NKF - National Kidney Foundation ONSP - Oral Nutrition Supplement Program PD - Peritoneal Dialysis POC - Plan of Care RN - Registered Nurse	V 000		
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.	V 147	**V147 494.30(a)(2) IC-STAFF EDUCATION – CATHETERS/CATHETER CARE** The Clinical Manager in-serviced facility staff 12/1/14 on the policy and procedure **FMS-CS-IC-I-105-041C2** initiating a CVC using Streamlines . On 12/10/14 the Education Coordinator in-serviced staff on the facility procedure as well. This second in-service included a new video available for staff demonstrating the proper procedure.	1/15/15

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FACILITY STANDARDS

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

12/12/14

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.

DIRECTOR OF OPERATIONS

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V 147	Continued From page 1 II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This STANDARD is not met as evidenced by: Based on observations, staff interview, and policy review it was determined the facility failed to ensure appropriate infection control measures were taken to prevent infections for 1 of 1 patients (Patient #9), who dialyzed using a central venous catheter and had the potential to impact all patients dialyzing with central venous catheters. This failure resulted in the potential for access acquired blood stream infections. Findings include: A policy titled "Termination of Treatment Using a Central Venous Catheter and Optiflux Single Use Ebeam Dialyzer," dated 6/19/13, gave instructions to scrub the CVC connections and hubs with alcohol and immediately attach the catheter lumens to a saline filled syringe for	V 147	Beginning the week of 12/8/14 the Clinical Manager and/or designee are to be notified of any dressing change in the unit for potential observation. This observation will present opportunities to ensure facility staff is following proper procedure. This practice will be continued daily for two weeks until such time as the Clinical Manager is confident staff is adhering to policy. Ongoing monitoring will continue with the regularly scheduled infection control audits implemented as part of the QAPI process. The mode of monitoring Catheter Care will consist of using the core survey field manual infection control audits (#1,2,3). Audits will be reviewed on a daily basis addressing any adversa trending and correcting staff members timely. If trending is identified with a specific staff member corrective action will be administered. Clinical Manager will present in QAI the results of all audit reports and monitoring as related to this Plan of Correction to the monthly QAI Committee for review and oversight. The Medical Director is to review the results presented at the QAI meeting and documented activity is appropriate for the deficiency, intervention is effective and that resolution is noted. The Director of Operations is responsible to present the status of the Plan of Correction with documentation as appropriate to the Governing Body on an	

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V 147	Continued From page 2 flushing. It further directed staff to "apply a sterile cap on the end of the lumen maintaining aseptic technique... Sterile caps prevent infection and provide protection between treatments." On 11/20/14 at 3:45 P.M., a staff was observed discontinuing treatment for Patient #9, who dialyzed using a CVC. The staff scrubbed the catheter connections and hubs with alcohol, disconnected the blood tubing from the catheter lumens, and retrieved two small clear plastic caps from a ledge on the side of the machine, applying them to the ends of the arterial and venous lumens. The disconnected tubing was secured to the machine. The staff then removed the clear plastic caps, flushed the catheter limbs, and applied red and blue caps from sterile packaging to the venous and arterial lumens. When asked at the time, the staff said the clear plastic caps were left from tubing used during set up of the machine prior to Patient #9's treatment and had been stored on the machine ledge during the treatment. When asked, staff said the caps had not been cleaned with an antiseptic. In an interview on 11/21/14 at 2:30 P.M., the nurse manager confirmed an aseptic procedure had not been performed. Infection control measures were not used when discontinuing dialysis for Patient #9.	V 147	ongoing basis until all issues related to the citations have been corrected and ongoing resolution is noted.	
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;	V 543	**V543 494.90(a)(1) POC-MANAGE VOLUME STATUS** On 12/1/14 the Clinic Manager in-serviced facility staff on Monitoring During Patient Treatment Policy **FMS-CS-IC-I-110-133**. A Specific emphasis was placed on the frequency requirement of 30 minute checks. Team reviewed the exact steps	1/16/15

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V 543	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of patient treatment records and policy and procedure, it was determined the facility failed to ensure blood pressure monitoring was done for 5 of 5 ICHD patients (Patients #1 - #5) whose records were reviewed. These failures resulted in patients being put at risk of complications resulting from hypotension and hypertension. Findings include: 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 30 minutes, or more frequently, as needed." The policy stated direct staff were to "verify and react to unusual findings such as atypical blood pressure readings." However, the policy was not implemented, as follows: a. Patient #3 was a 76 year old male who had been dialyzing at the facility since 2/25/13. Treatment sheets from 10/21/14 - 11/15/14 were reviewed. Patient #3 did not have vital signs monitored per policy during nine of twelve, 75%, of treatments as follows: 10/21/14 - No vital signs were taken from 0803 until 1015 and again from 1015 until 1137. 10/23/14 - No vital signs were taken from 1157 until 1245 during which time Patient #3's BP had dropped from 156/71 to 101/62. At 1309, Patient #3's BP was 98/60 and vitals were not retaken until 1413. 10/28/14 - Patient #3's BP at 0944, the initiation of treatment, was 148/62. At 1313 Patient #3's BP was 86/55. Vital signs were not monitored	V 543	necessary to capture machine data and clinical system to ensure data is transferred from the machine to the clinical record timely. Clinical Manager or designee for a period of two weeks will daily monitor 25% of patient treatment sheets for variances from half hour checks or other missed documentation opportunities. Adherence to the policy will result in the frequency reduced to 25% 3X weekly for two additional weeks and then 25% once a week for two weeks. This auditing will continue until progress is noted and any identified root causes for non-adherence are resolved. Continued oversight will continue utilizing the medical records audit contained within the QAI process. Clinical Manager will present in QAI the results of all audit reports and monitoring as related to this Plan of Correction to the monthly QAI Committee for review and oversight. The Medical Director is to review the results presented at the QAI meeting and documented activity is appropriate for the deficiency, intervention is effective and that resolution is noted. The Director of Operations is responsible to present the status of the Plan of Correction with documentation as appropriate to the Governing Body on an ongoing basis until all issues related to the citations have been corrected and ongoing resolution is noted.	

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V 643	Continued From page 4 again until the end of treatment at 1345 when his BP was recorded at 90/80. 10/30/14 - Pre treatment BP was recorded at 147/81. No vital signs were taken from initiation at 0859 until 0954 at which time Patient #3's BP was 97/62. Again no vital signs were recorded from 0954 until 1045 at which time his BP was 89/60. Fluid removal was stopped at 1046. BP was recorded as 96/64 at 1101 but was not monitored again until 1203 at which time Patient #3 continued to be hypotensive with a BP of 95/48. 11/1/14 - No vital signs were taken from 0915 until 1014 and again from 1014 until 1107 at which time Patient #3's BP had decreased from 107/55 to 93/58. No interventions were documented. 11/4/14 - Vital signs were not recorded from 0936 until 1030 at which time Patient #3's BP was 84/52 and interventions were taken. Again from 1100 until 1200 no vital signs were recorded. 11/8/14 - At 1130, Patient #3's BP was recorded as 81/50. Vital signs were not retaken until 1217. 11/13/14 - Patient #3's pre treatment BP was documented as 192/87 at 0918. At 1034, Patient #3's BP was recorded as 92/56. It was not retaken until 1146 at which time BP was recorded as 95/63. Again BP was not retaken until 1222 when it was documented as 85/50. Interventions were documented at this time, nearly two hours after Patient #3's systolic BP reading had decreased by nearly 100 points. 11/15/14 - No vital signs were recorded from 1105	V 643	**Intentionally Left Blank**	

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V 543	Continued From page 5 until 1204 and again from 1204 until the end of treatment at 1264. b. Patient #1 was a 62 year old male who had been dialyzing at the facility since 10/23/14. Treatment sheets from 10/23/14 - 11/15/14 were reviewed. Patient #1 did not have vital signs monitored per policy during five of nine, 56%, of treatments as follows: 10/23/14 - No vital signs were recorded from 1436 until 1531. 11/6/14 - No vital signs were taken from initiation of treatment at 1122 until 1229. 11/10/14 - No vital signs were recorded from 0843 until the end of treatment at 1009. 11/11/14 - No vital signs were recorded from 1233 until 1333, and again from 1433 until 1520. 11/13/14 - No vital signs were taken from 1232 until 1333, and again from 1504 until the end of treatment at 1552. c. Patient #5 was a 73 year old female who had been dialyzing at the facility since 10/12/10. Treatment sheets from 10/20/14 - 11/17/14 were reviewed. Patient #5 did not have vital signs monitored per policy during seven of thirteen, 54%, of treatments as follows: 10/20/14 - Vital signs were not recorded from 1410 until 1500 and again from 1500 until 1603, the end of treatment. 10/27/14 - Vital signs were not recorded from	V 543	Intentionally Left Blank	

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V 543	Continued From page 6 1500 until 1608. 11/3/14 - No vitals were recorded from 1304 until 1530 and again from 1530 until 1623. Vitals were monitored three times during a 4 hour treatment. 11/5/14 - No vitals were recorded from 1332 until 1513 and again from 1513 until the end of treatment at 1609. Vitals were monitored four times during a 4 hour treatment. 11/10/14 - Vitals were not monitored from 1358 until 1505. 11/14/14 - Vitals were not monitored from initiation of treatment at 1204 until 1308. 11/17/14 - Vital signs were not monitored from 1403 until 1535. d. Patient #2 was a 26 year old female who had been dialyzing at the facility since 6/9/12. Treatment sheets from 10/21/14 - 11/16/14 were reviewed. Patient #2 did not have vital signs monitored per policy during two of ten, 20%, of treatments as follows: 10/23/14 - No vital signs were taken from 0924 until 1032 and again from 1102 until 1205. 11/16/14 - No vital signs were taken from 1024 until 1130 and again from 1206 until 1334. e. Patient #4 was a 45 year old female who had been dialyzing at the facility since 3/26/09. Treatment sheets from 10/20/14 - 11/17/14 were reviewed. Patient #4 did not have vital signs monitored per policy during three of thirteen, 23%, of treatments as follows:	V 543	Intentionally Left Blank	

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V 543	Continued From page 7 10/27/14 - Vital signs were not monitored from 0638 until 0739. 11/3/14 - No vital signs were monitored from 0646 until 0804. 11/14/14 - No vital signs were monitored from 0612 until 0706. During an interview on 11/21/14 at 2:30 P.M., the nurse manager confirmed the lack of monitoring for Patients #1 -#5. The facility did not provide appropriate monitoring of five patients during their treatments.	V 543		
V 545	494.90(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS The interdisciplinary team must provide the necessary care and counseling services to achieve and sustain an effective nutritional status. A patient's albumin level and body weight must be measured at least monthly. Additional evidence-based professionally-accepted clinical nutrition indicators may be monitored, as appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an acceptable albumin level was achieved and sustained for 1 of 2 PD patients (Patient #7), whose serum albumin levels did not reach goal. This failure put the patient at risk of complications from chronically low nutritional markers. Findings include:	V 545	**V545 494.90.(a)(2) POC-EFFECTIVE NUTRITIONAL STATUS** On 12/10/14 Exit Survey results were discussed with facility personnel reviewing the findings as a part of the plan of correction. The Director of Operations HT reviewed the Nutritional Services Policy **FMS-CS-IC-I-111-001A** where the responsibilities were detailed for the Registered Dietician. The RD will be charged with providing an individualized nutritional recommendation which actively promotes patients effective nutritional status. All recommendations will be brought before the physician for approval and documented in the patients Plan of Care **FMS-CS-IC-I-110-125D3.** Deviation from the nutritional recommendations resulting in weight loss	

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V 645	Continued From page 8 Serum albumin level for dialysis patients was recommended by KDOQI Nutrition Standards, 2000, to be 4.0 g/dl or greater. Patient #7 was a 60 year old female who had been dialyzing at the facility since 3/11/13, using peritoneal dialysis as her current modality. Laboratory values for her serum albumin were reviewed and were found to average 2.66 g/dl for the six months of June - November 2014. Patient #7's POCs documented the following: June 2014 - Albumin 2.8 g/dl. "Consider IDPN. Provide education to patient and spouse." July 2014 - Albumin 2.6 g/dl. "Initiate IDPN." August 2014 - Albumin 2.7 g/dl. "Education provided to patient and spouse. Patient is on ONSP. IDPN discontinued per company policy. Continue to expect low albumins. Provide options for supplements outside ONSP (NKF grant). Monitor monthly and address as needed with patient and spouse. Encourage adherence to diet/medications." September 2014 - Albumin 2.4 g/dl. "IDPN discontinued per company policy. ONSP in place. Now in the hospital. Review when back in center. Encourage adherence to diet/medications." Patient #7's record documented she was hospitalized from 9/9 - 10/15/14 for wound debridement and healing. At the time of the survey, she was continuing to receive wound care at home through home health services.	V 645	or adverse conditions will be addressed in a timely manner. Upon first availability of Lead Registered Dietician or designee core job functions will be reviewed. Lead RD or designee will in-service the dietary staff on how to run lab reports showing a trended value of patient labs. The dieticians will identify patients with albumin lab values less than 4.0. The Dieticians will then cross reference the Albumin report to Orders for nutritional supplements. Going forward all patients less than 3.5 will be checked to ensure that they are receiving a nutritional supplement. Patients refusing nutritional supplements will be brought to the MSW attention to help in identifying root causes for declining appetite or food intake. Root causes will be addressed with physician and the rest of the interdisciplinary team. Education will be provided to patients or patient guardian with albumin levels <3.5. Educational efforts will be to assist in promoting the message of adequate albumin and the risks of low albumin. Education efforts will be documented in the patient's plan of care and review by the interdisciplinary team. The Director of Operations is responsible to present the status of the Plan of Correction with documentation as appropriate to the Governing Body on an ongoing basis until all issues related to the citations have been corrected and ongoing resolution is noted.	

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V 545	Continued From page 9 October 2014 - Albumin 2.5 g/dl. "Education provided. Encourage adherence to diet/medication. Protein supplement ONSP. Monthly labs drawn and reviewed." November 2014 - Albumin 2.6 g/dl. "Continue to monitor albumin. Evaluate non-nutritional causes of low albumin. Review ways to increase calorie &/or protein intake. Menus given to patient and spouse. Continue use of oral nutritional supplements as appropriate, ONSP. No IDPN per company policy." In an interview on 11/20/14 at 2:00 P.M., the dietician explained the facility's ONSP program. She said any patient with albumin values below 3.5 g/dl were eligible to receive 156 doses of a protein supplement each year, free of charge, from the facility. The patients could choose the supplement either in a bar form, a concentrated liquid or a flavored drink. The dietician confirmed Patient #7 had been active in the ONSP program and provided documentation that Patient #7 was receiving and ingesting the provided protein supplements. She did not know if additional supplement funding had been pursued for Patient #7, as suggested in the August POC. Further,the dietician confirmed Patient #7 had received IDPN for a short period of time before it was discontinued because it was "against company policy." In an interview on 11/20/14 at 4:00 P.M., the facility's Home Therapies Area Manager stated IDPN had been removed as a treatment option from all corporate PD programs "for further evaluation." It was not clear if or when IDPN might be available to patients.	V 545	**Intentionally Left Blank**	

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V 545	Continued From page 10 The IDT did not provide and implement a POC for Patient #7 to achieve effective nutritional status.	V 545		
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 and staff interview, it was determined the facility failed to ensure clinical competencies were demonstrated by 3 of 3 Home Program Training nurses (Staff A - C), whose personnel records were reviewed. This resulted in a lack of qualified staff to support patients who chose HHD as their dialysis modality. Findings include: The facility's CMS form 3427, signed by the facility's Clinical Manager and dated 11/18/14 stated the facility provided home therapy dialysis options to patients, including PD and home hemodialysis. In an interview on 11/17/14 at 3:00 P.M., the home program nurse manager said home hemodialysis was offered, and training provided, using the NxStage dialysis machine. Review of Staff A's personnel record showed she	V 681	**V681 499.140 PQ-STAFF LIC AS REQ/QUAL/DEMO COMPETENCY.** The Home Therapy Program Manager will complete a HHD didactic class on 11/24/2014. After the didactic class is completed an Education Coordinator will complete the annual skills checks on 12/04/2014. When this is completed the Home Therapy Program Manager will report to the Governing Body that her annual skills competency checks are completed. After the Home Therapy Program Manager's annual competency checks are completed, the remaining Home Therapy nurses will start the HHD training program, which will include training new patients, monitoring parameters, water testing, supply management, and HHD policy and procedure review. If there is a new patient that needs to be trained during this time frame, the Home Therapy Program Manager will oversee the patient training. If the Home Therapy Program Manager is unable to train a new patient, arrangements will be made to bring in a certified HHD nurse from the Liberty Dialysis Meridian Home program located in Meridian ID. The Director of Operations is responsible to present the status of the Plan of Correction with documentation as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132523	A. BUILDING _____ B. WING _____	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS CALDWELL	1620 ENTERPRISE WAY, SUITE 101 CALDWELL, ID 83605

(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 681	Continued From page 11 had been hired on 6/4/13, to perform RN responsibilities in the home therapies program. This included the training and support of patients choosing PD and HHD modalities. There were no documented clinical competencies for Staff A showing she was currently qualified to train and support patients choosing HHD as their dialysis modality. Review of Staff B's personnel record showed she had been hired on 10/14/13, to perform RN responsibilities in the home therapies program. This included the training and support of patients choosing PD and HHD modalities. There were no documented clinical competencies for Staff B showing she was currently qualified to train and support patients choosing HHD as their dialysis modality. Review of Staff C's personnel record showed she had been hired on 8/17/05. She performed manager/RN responsibilities in the home therapies program. This included the training and support of patients choosing PD and HHD modalities. There were no documented clinical competencies for Staff C showing she was currently qualified to train and support patients choosing HHD as their dialysis modality. In an interview on 11/19/14 at 5:00 P.M., the nurse manager confirmed Staff A and Staff B were not familiar with the NxStage dialysis machine and did not have the clinical competencies to train and support a patient choosing HHD as their modality. Further, the nurse manager said she would train patients choosing HHD as their dialysis modality. However, when asked in the same interview, she	V 681	appropriate to the Governing Body on an ongoing basis until all issues related to the citations have been corrected and ongoing resolution is noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132523	A. BUILDING _____ B. WING _____	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS CALDWELL	4620 ENTERPRISE WAY, SUITE 101 CALDWELL, ID 83605

(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 681	Continued From page 12 said her most recent clinical competencies were documented in 2007. The facility did not have staff with demonstrated clinical competencies to train and support patients in the HHD program.	V 681	**V764 494.180(d) GOV-SERVICES FURNISHED ON THE MAIN PREMISES** To provide consistent and comprehensive review of the HHD modality, staffing will complete annual training and competencies. Training and Competencies will be managed by the Clinic manager or designee updating documentation in the staffing records. In relation to V681 the HT Program Manager attended her annual didactic course (11/24/14) in addition to completing her skills validation. The didactic course was proctored by the HT Education Coordinator and verified competencies. With HHD Certification the HT Program Manager will actively accept HHD patients. Along with certification the HT Program Manager will verify skills and train additional staff members with the end result being HHD Certified RNs. As it relates to the Governing Body, the Governing Body members will review all HHD staffing competencies in the quarterly meetings ensuring staff are trained and competent. The Director of Operations is responsible to present the status of the Plan of Correction with documentation as appropriate to the Governing Body on an ongoing basis until all issues related to the citations have been corrected and ongoing resolution is noted.	
V 764	494.180(d) GOV-SERVICES FURNISHED ON THE MAIN PREMISES The governing body is responsible for ensuring that the dialysis facility furnishes services directly on its main premises or on other premises that are contiguous with the main premises and are under the direction of the same professional staff and governing body as the main premises (except for services provided under §494.100). This STANDARD is not met as evidenced by: Based on personnel record review and staff interview, it was determined the governing body failed to ensure home hemodialysis training could be provided at the facility. This failure had the potential to impact all patients choosing HHD as a preferred modality. Findings include: Refer to V681 as it relates to the lack of competently trained staff available at the facility for the training and support of patients choosing the HHD modality.	V 764		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 1, 2014

Shelby Wright, Administrator
Liberty Dialysis Caldwell
4620 Enterprise Way, Suite 101
Caldwell, ID 83605-6764

Provider #132523

Dear Ms. Wright:

On **November 21, 2014**, a complaint survey was conducted at Liberty Dialysis Caldwell. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006736

Allegation #1: The drains on the treatment floor contain mold that attracts insects.

Findings #1: An unannounced visit was made to the facility from 11/17/14 - 11/21/14. Ten hours of cumulative observation was done as well as a physical inspection of the facility with the following results:

A close physical inspection of four drains on the treatment floor showed them to be free of mold and no insect infestation was noted. The drains were covered with a perforated plastic dome.

In an interview on 11/18/14 at 9:00 A.M., the biomedical technician stated he was the person responsible for facility maintenance on a day to day basis. When asked, he said the perforated plastic domes were present to prevent the drain air gap spaces from collecting trash and debris. He further stated each drain was cleansed on a weekly basis when staff poured excess vinegar and bleach into the drain chases after using the products for dialysis machine disinfection.

It could not be determined that the drains contained mold. Therefore, the allegation was unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Unauthorized persons have access to patient health information.

Findings #2: An unannounced visit was made to the facility from 11/17/14 - 11/21/14. Observations and staff interviews were conducted with the following results:

During a cumulative ten hours of observations, no unauthorized persons were observed to have access to patient health information.

In an interview on 11/21/14 at 12:00 P.M., the Administrative Assistant said she and one other staff member were responsible for filing and maintaining patients' medical records. She further stated the facility did not use volunteer persons or temporary help for the maintenance of medical records.

It could not be determined that unauthorized persons had access to patient health information. Therefore, the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nursing assessments are not performed prior to patients' dialysis treatments.

Findings #3: An unannounced visit was made to the facility from 11/17/14 - 11/21/14. Observations, staff interviews and record reviews were conducted with the following results:

During a cumulative ten hours, patients were observed entering the facility to begin their scheduled dialysis treatments. During the observations, one or two Registered Nurses were consistently present on the treatment floor. Twelve of 12 patients observed received assessments from the nurses prior to or immediately after the initiation of dialysis treatment. These assessments consisted of questioning the patients concerning physical symptoms as well as physical examination for lung sounds, heart sounds and the presence of edema.

Additionally, the records of 5 patients, who were not observed, were reviewed. The records documented nursing assessments which had been completed.

In an interview on 11/19/14 at 11:00 A.M., a staff nurse, who had recently completed orientation to the facility, said the need for nursing assessment was included in her training and was a routine part of patient admission.

It could not be determined that pre-treatment nursing assessments were not being performed. Therefore, the allegation was unsubstantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Doctors prescribe excessive narcotics to patients.

Findings #4: Part 494 Conditions for Coverage for End Stage Renal Disease Facilities has no governance concerning physicians' prescribing activities.

Conclusion #4: No regulatory basis.

Allegation #5: Sharps containers are not replaced when full.

Findings #5: An unannounced visit was made to the facility from 11/17/14 - 11/21/14. Observations and staff interviews were conducted with the following results:

During ten cumulative hours of observations, large sharps containers were noted to be positioned at each of thirteen patient dialysis stations. These containers were observed to be used by staff for the disposal of dialysis needles at the end of patient treatment. During observations, none of the containers were seen to be more than half full.

In an interview on 11/17/14 at 4:00 P.M., two direct care staff said the sharps containers had markings on them to indicate a full level. Staff further stated it was their responsibility to close full sharps containers, place them in a biohazard waste disposal room, and replace them with clean, empty containers.

It could not be determined that sharps containers were allowed to remain unattended when full. Therefore, the allegation was unsubstantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt